substances, Hazardous Waste, Intergovernmental relations, Penalties, Reporting and recordkeeping requirements, Superfund, Water pollution control, Water supply.

Dated: October 17, 1997.

David Ullrich,

Acting Regional Administrator, U.S. EPA, Region V.

40 CFR part 300 is amended as follows:

PART 300—[AMENDED]

1. The authority citation for part 300 continues to read as follows:

Authority: 33 U.S.C. 1321(c)(2); 42 U.S.C. 9601–9657; E.O. 12777, 56 FR 54757, 3 CFR, 1991 Comp.; p. 351; E.O. 12580, 52 FR 2923, 3 CFR, 1987 Comp.; p. 193.

Appendix B—[Amended]

2. Table 1 of Appendix B to part 300 is amended by removing the Site ''Bowers Landfill, Circleville County, Ohio.''

[FR Doc. 97–28552 Filed 10–28–97; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 300

[FRL–5914–4]

National Oil and Hazardous Substances Contingency Plan; National Priorities List Update

AGENCY: Environmental Protection Agency.

ACTION: Notice of deletion of the Northern Engraving Corporation Superfund Site from the National Priorities List (NPL).

SUMMARY: The Environmental Protection Agency (EPA) announces the deletion of the Northern Engraving Corporation Superfund Site in Wisconsin from the National Priorities List (NPL). The NPL is Appendix B of 40 CFR part 300 which is the National Oil and Hazardous Substances Contingency Plan (NCP), which EPA promulgated pursuant to section 105 of the Comprehensive Environmental Response, Compensation, and Liability Act of 1980 (CERCLA), as amended. This action is being taken by EPA and the State of Wisconsin, because it has been determined that Responsible Parties have implemented all appropriate response actions required. Moreover, EPA and the State of Wisconsin have determined that remedial actions conducted at the site to date remain protective of public health, welfare, and the environment.

EFFECTIVE DATE: October 29, 1997.

FOR FURTHER INFORMATION CONTACT: Robert Whippo (312) 886–1476 (SR–6J), Remedial Project Manager or Gladys Beard at (312) 886–7253, Associate Remedial Project Manager, Superfund Division, U.S. EPA—Region V, 77 West Jackson Blvd., Chicago, IL 60604. Information on the site is available at the local information repository located at: Sparta Free Library, W. Main & Court Sts., Sparta, WI 54656. Requests for comprehensive copies of documents should be directed formally to the Regional Docket Office. The contact for the Regional Docket Office is Jan Pfundheller (H–7J), U.S. EPA, Region V, 77 W. Jackson Blvd., Chicago, IL 60604, (312) 353–5821.

SUPPLEMENTARY INFORMATION: The site to be deleted from the NPL is: Northern Engraving Corporation Superfund Site located in Sparta, Wisconsin. A Notice of Intent to Delete for this site was published September 11, 1997 (62 FR 47784). The closing date for comments on the Notice of Intent to Delete was October 10, 1997. EPA received no comments and therefore no Responsiveness Summary was prepared.

The EPA identifies sites which appear to present a significant risk to public health, welfare, or the environment and it maintains the NPL as the list of those sites. Sites on the NPL may be the subject of Hazardous Substance Response Trust Fund (Fund-) financed remedial actions. Any site deleted from the NPL remains eligible for Fund-financed remedial actions in the unlikely event that conditions at the site warrant such action. Section 300.425(e)(3) of the NCP states that Fund-financed actions may be taken at sites deleted from the NPL in the unlikely event that conditions at the site warrant such action. Deletion of a site from the NPL does not affect responsible party liability or impede agency efforts to recover costs associated with response efforts.

List of Subjects in 40 CFR Part 300

Environmental protection, Air pollution control, Chemicals, Hazardous substances, Hazardous Waste, Intergovernmental relations, Penalties, Reporting and recordkeeping requirements, Superfund, Water pollution control, Water supply.

Dated: October 17, 1997.

David Ullrich,

Acting Regional Administrator, U.S. EPA, Region V.

40 CFR part 300 is amended as follows:

PART 300—[AMENDED]

1. The authority citation for part 300 continues to read as follows:

Authority: 33 U.S.C. 1321(c)(2); 42 U.S.C. 9601–9657; E.O. 12777, 56 FR 54757, 3 CFR, 1991 Comp.; p. 351; E.O. 12580, 52 FR 2923, 3 CFR, 1987 Comp.; p. 193.

Appendix B—[Amended]

2. Table 1 of Appendix B to part 300 is amended by removing the Site ''Northern Engraving Co., Sparta, Wisconsin.''

[FR Doc. 97–28551 Filed 10–28–97; 8:45 am]

BILLING CODE 6560–50–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Part 489

[BPD–748–F]

RIN 0938–AG03

Medicare Program; Changes in Provider Agreement Regulations Related to Federal Employees Health Benefits

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

ACTION: Final rule.

SUMMARY: This final rule makes two changes to Medicare's provider agreement regulations concerning payment for inpatient hospital services furnished to retired enrollees of fee-for-service Federal Employees Health Benefits (FEHB) plans who do not have Medicare Part A coverage. The first change specifies that payment for inpatient hospital services furnished to retired Federal workers age 65 or older who are enrolled in a fee-for-service FEHB plan but are not covered under Medicare Part A is limited to a payment amount that approximates the Medicare diagnosis-related group payment rates established under Medicare's inpatient hospital prospective payment system.

The second change specifies that HCFA will consider termination or nonrenewal of a hospital's provider agreement with Medicare if a hospital knowingly and willfully fails to accept, on a repeated basis, the Medicare rate as payment in full for inpatient hospital services provided to a retired Federal worker who is enrolled in a fee-for-service FEHB plan and who does not have Medicare Part A coverage.

This final rule implements section 7002(f) of the Omnibus Budget Reconciliation Act of 1990.

EFFECTIVE DATE: These regulations are effective on November 28, 1997.

ADDRESSES: Copies: To order copies of the **Federal Register** containing this document, send your request to: New Orders, Superintendent of Documents, P.O. Box 37194, Pittsburgh, PA 15250–7954. Specify the date of the issue requested and enclose a check or money order payable to the Superintendent of Documents, or enclose your Visa or Master Card number and expiration date. Credit card orders can also be placed by calling the order desk at (202) 512–1800 or by faxing to (202) 512–2250. The cost for each copy is $8. As an alternative, you can view and photocopy the **Federal Register** document at most libraries designated as Federal Deposit Libraries and at many other public and academic libraries throughout the country that receive the **Federal Register**.

This **Federal Register** document is also available from the **Federal Register** online database through GPO Access, a service of the U.S. Government Printing Office. Free public access is available on a Wide Area Information Server (WAIS) through the Internet and via asynchronous dial-in. Internet users can access the database by using the World Wide Web; the Superintendent of Documents home page address is http://www.access.gpo.gov/su__docs/, by using local WAIS client software, or by telnet to swais.access.gpo.gov, then login as guest (no password required). Dial-in users should use communications software and modem to call (202) 512–1661; type swais, then login as guest (no password required).

FOR FURTHER INFORMATION CONTACT: David Walczak, (410) 786–4475.

SUPPLEMENTARY INFORMATION:

I. Background

The Office of Personnel Management (OPM) administers the Federal Employees Health Benefits (FEHB) program. This program provides health insurance coverage to current Federal employees, retired Federal workers, and their eligible family members. While most retired Federal employees age 65 or older are eligible to receive hospital insurance benefits under Medicare Part A, some retired Federal workers are not covered. This group generally encompasses those Federal workers who retired from the Federal Government before January 1, 1983, and who did not have Medicare withholdings taken from their salary while employed with the Federal Government or did not acquire coverage in another way.

Existing Medicare provider agreement regulations at 42 CFR 489.21(a) specify that a provider must agree not to charge a beneficiary for services for which the beneficiary is entitled to have payment made under Medicare. Under this provision, the provider agrees to accept Medicare payment in full for services covered under Medicare and furnished by the provider. However, the regulations do not require that hospitals accept the Medicare hospital inpatient prospective payment system (PPS) rate as payment in full when issued by a fee-for-service FEHB plan for a FEHB enrollee not covered by Medicare Part A.

Section 7002(f) of the Omnibus Budget Reconciliation Act of 1990 (OBRA '90) (Pub. L. 101–508) requires that fee-for-service FEHB plans limit their inpatient payment for services furnished to retired FEHB enrollees age 65 and older who are not covered under Medicare Part A to rates that would have been paid by Medicare under section 1886 of the Social Security Act (the Act). Under sections 1886 (d) and (g) of the Act, Medicare payment for hospital inpatient operating and capital-related costs is made at a predetermined specific rate for each hospital discharge based on the assigned diagnosis-related group (DRG) for each patient. Thus, a hospital knows at the time of discharge what Medicare will pay for each discharge.

Section 7002(f) of OBRA '90 also requires that OPM notify the Secretary of Health and Human Services (the Secretary) of incidents when a hospital knowingly and willfully attempts to collect, on a repeated basis, more than the Medicare payment rates. The Secretary may consider such incidents as violations of the Medicare provider agreement and may terminate or refuse to renew the agreement. A Medicare provider agreement is an agreement between HCFA and providers specified in regulations to furnish services to Medicare beneficiaries and to comply with section 1866 of the Act, which establishes conditions that providers must meet in order to have an agreement to participate in the Medicare program. HCFA may terminate a provider agreement if any of the failings listed in regulations at § 489.53(a) are attributable to a provider.

On February 10, 1994, we published in the **Federal Register** (59 FR 6228) a proposed rule to revise regulations in Part 489 to implement section 7002(f) of OBRA '90. We proposed to:

- Amend § 489.21, which sets forth specific limitations on charges under Medicare provider agreements, to make the limitations on payment for inpatient hospital services applicable to services furnished to retired fee-for-service FEHB plan enrollees age 65 or older who are not covered under Medicare Part A hospital benefits.
- Specify, under a new § 489.21(I), that a provider may not attempt to collect more than the amount established for Medicare purposes for inpatient hospital services under section 1886 of the Act.
- Add a new § 489.53(a)(13) to specify that HCFA will consider termination or nonrenewal of a Medicare provider agreement with any hospital that knowingly and willfully fails to accept, on a repeated basis, the Medicare rate established under the inpatient hospital PPS system, minus any applicable health plan deductibles or copayments, as payment in full from a fee-for-service FEHB plan.

Our February 10, 1994 proposed rule paralleled the provisions of a July 20, 1993 OPM final rule (58 FR 38661) that defined a retired enrolled individual and set forth the circumstances under which the limit on hospital charges and FEHB benefit payments take effect.

II. Analysis of and Responses to Public Comments

We received four letters of comment on the February 10, 1994, proposed rule. A summary of these comments and our responses are discussed below.

Comment: Two commenters identified a number of problems with the administrative procedures designed to enforce the limit on inpatient charges and to monitor overcharges in fee-for-service plans. One commenter stated that the oversight process relies on the FEHB plan having a good system for cross-referencing actual charges against the limits placed on hospital inpatient charges. The same commenter also expressed concern over the lack of any provision for enrollee input into the compliance process, except when an enrollee notices that an overcharge has been billed and then notifies the FEHB plan or OPM. A second commenter noted that there is no incentive for monitoring overcharges in fee-for-service plans, since these plans base future premiums on prior claims experience. The same commenter pointed out that the fee-for-service plans usually pay coinsurances and copayment amounts based on charges submitted by providers, and that the plans will not pursue potential overcharges, especially when the hospital is a preferred provider for the plan.

Response: We believe that there are adequate procedures and controls in place among the FEHB plans, OPM, and HCFA to monitor overcharges in fee-for-service plans covering retired Federal

enrollees age 65 or older who do not have Medicare Part A hospital coverage.

OPM is responsible for administering the day-to-day operations of the FEHB program. OPM's regulations governing the FEHB program are described in 5 CFR part 890. Regulations describing the limits are in subpart I of part 890. The FEHB plans inform both the hospital and the enrollee of the limits on inpatient charges for covered Medicare inpatient hospital services provided to a retired Federal enrollee age 65 or older who does not have Medicare Part A benefits. The FEHB plans inform their enrollees through an explanation of benefits (EOB) statement, that describes what the plan pays for, the amount the enrollee must pay, the limits on inpatient hospital charges for Medicare-covered services, and the date each service was provided. The limits on hospital inpatient charges are also covered in the plans' benefit brochures. FEHB plans inform hospitals that a hospital cannot collect more than what Medicare would have paid if the FEHB enrollee had been covered by Medicare Part A. In other words, the fee-for-service FEHB plan pays the hospital an amount that approximates as closely as possible the Medicare payment rate, minus any enrollee deductibles or copayment amounts.

Since FEHB plans do not have a system in place for routinely checking for overcharges, any discrepancies are brought to the attention of a fee-for-service FEHB plan by an enrollee. According to OPM, overbilling of retired Federal enrollees of fee-for-service FEHB plans is not a problem. There have been no known instances of a hospital repeatedly overbilling. On the other hand, there have been a few instances where hospitals have disagreed with the Medicare prospective payment system rates that have been paid by the fee-for-service FEHB plans. Disputes over the determination of the equivalent DRG payment rate have been resolved on a case-by-case basis between the fee-for-service FEHB plans and hospital providers.

If there are instances of overbilling, fee-for-service FEHB plans must inform the hospital that it is violating the law. If the hospital does not comply with the law after being notified, the fee-for-service FEHB plans must notify OPM. If OPM determines that a hospital knowingly and willfully attempted to collect more than the Medicare payment rate for inpatient hospital services, OPM notifies HCFA to take appropriate action. HCFA is authorized to either terminate or nonrenew a hospital's provider agreement to participate in Medicare, in accordance with section 1866(b)(2) of the Act.

HCFA's authority to take enforcement action against a hospital by stopping its Medicare reimbursement serves as a powerful and effective incentive for a hospital to follow acceptable billing practices. There is also a strong incentive for fee-for-service FEHB plans to ensure that a hospital is charging within the acceptable limits. If enrollees are continually being overcharged, they likely will become dissatisfied with a plan's service, and may eventually switch health plans. We believe that if the health plans want to keep enrollees as customers, fee-for-service FEHB plans will make every effort to monitor, prevent, and correct a hospital's overbilling as much as possible.

Comment: One commenter stated that the language on HCFA termination of Medicare provider agreements in § 489.53(a)(13) is broad and permissive. The commenter pointed out that a provider may misinterpret the words. ''HCFA *may* terminate the agreement if the provider *knowingly and willfully* charges, *on a repeated basis* * * *'', and suggested replacing the word ''may'' with the word ''will.''

Response: Section 489.53(a) establishes HCFA's authority to terminate a provider's agreement and outlines the circumstances under which HCFA may proceed with the termination action. The phrase ''may terminate'' is used in the regulation rather than ''will terminate'' because it provides HCFA with the discretion to evaluate each situation carefully and to apply the termination provisions fairly. Thus, HCFA is not forced to arbitrarily terminate a provider's agreement if mitigating circumstances apply.

In addition, the phrases ''* * * knowingly and willfully * * *'', ''* * * on a repeated basis * * *'', and ''* * * may * * *'' are language taken directly from section 7002(f) of OBRA '90. Our regulations at § 489.53 are based on the language and intent of this statute. The important point is that when OPM notifies HCFA that a violation has occurred, HCFA will investigate and make every attempt to enforce the requirements of the statute and regulations.

Comment: One commenter believed that fee-for-service FEHB plans should inform their enrollees who are without Medicare Part A hospital benefits that their hospital bills have been reviewed, to assure that the inpatient charges do not exceed the Medicare approved payment amounts.

Response: OPM has taken several measures to inform enrollees of fee-for-service FEHB plans of the limits on inpatient hospital charges and fee-for-service FEHB plan payments. First, OPM published the 1991 Open Season Information and Instructions for Annuitants and included an explanation of the limits in a highlighted section entitled ''Attention All Enrollees''. In addition, an explanation of the limits has been included in all brochures of fee-for-service health plans of the FEHB program beginning in 1992 through the present.

As stated in a previous response, a fee-for-service FEHB plan informs both the hospital and the enrollee of the current Medicare approved payment limits. The FEHB plan notifies the enrollee what the enrollee is obligated to pay (the deductible or copayment amount) in the EOB statement. When a fee-for-service FEHB plan receives a hospital bill for an enrollee covered by section 7002(f) of OBRA '90, the FEHB plan pays the hospital an amount that approximates the Medicare DRG payment amount minus any enrollee deductible or copayment. Thus, a hospital bears the responsibility not to collect more than the Medicare DRG payment rate established under the inpatient hospital prospective payment system, minus any enrollee deductibles or copayments, as payment in full from a fee-for-service FEHB plan. HCFA may terminate or nonrenew a hospital's provider agreement with Medicare, if OPM reports that a hospital is refusing to accept an amount that approximates the Medicare rate as payment in full for inpatient hospital services provided to a retired Federal worker who is enrolled in a fee-for-service FEHB plan and who does not have Medicare Part A.

Comment: One commenter believed that it is sometimes difficult to identify the appropriate primary payer types for all patients. Thus, the commenter recommended that every retired Federal enrollee who is not covered under Medicare Part A be issued an identification card to be presented when the individual receives inpatient hospital services. The commenter also suggested that the card include a message on one side stating that the card carrier is a Medicare limited-reimbursement patient, and display an accompanying telephone number for benefit information.

Response: As noted above, OPM has operational authority over the administration of the FEHB program. HCFA does not have any responsibility in this area. We have forwarded this suggestion to OPM for its consideration.

However, OPM did comment to us that the cost of producing a different identification card for retirees over age 65 not covered by Medicare Part A

cannot be justified when FEHB plans inform hospitals each time the limits apply, and by now, hospitals know the category of individuals that are covered by the limits.

Comment: One commenter stated that the proposed rule did not address the Medicare payment limits established for providers that are excluded from PPS, such as psychiatric hospitals and units, rehabilitation hospitals and units, long-term care hospitals, children's hospitals, and cancer hospitals. Providers that are excluded from PPS are paid on a reasonable cost basis, subject to a hospital-specific target rate per discharge.

Response: Section 7002(f) of OBRA '90 specifies that a hospital may not charge more than the limitations on hospital charges established under section 1886 of the Act to fee-for-service FEHB plans for inpatient hospital services provided to retired Federal enrollees age 65 or older who do not have Medicare Part A hospital coverage. Section 1886 of the Act refers to Medicare payment to hospitals for inpatient services, which could be construed as including both the PPS rates and the payment limits for hospitals excluded from PPS. Both OPM and HCFA interpret that the intent of section 7002(f) of OBRA '90 applies only to hospitals that are paid under the PPS as specified in sections 1886(d) and (g) of the Act. On the other hand, hospitals and units that are excluded from PPS are paid on a reasonable cost basis, known as the TEFRA payment system, and are not intended to be covered under section 7002(f) of OBRA '90. There are a number of operational and administrative reasons why the limits on a fee-for-service FEHB plan's payment to a hospital for inpatient services provided to a retired Federal enrollee, age 65 or older, who is without Medicare Part A, are subject to Medicare's prospective payment system, rather than to Medicare's reasonable cost system of payment (TEFRA).

First, under PPS, payment for acute inpatient hospital stays under Medicare Part A are based on prospectively set rates. Under this system, Medicare payment is made at a predetermined, specific rate for each hospital discharge, according to a DRG payment rate. A PPS hospital generally knows at the time of discharge what Medicare will pay for each Medicare discharge. In contrast, Medicare payment to providers subject to the TEFRA target limit is based on total Medicare discharges times a hospital-specific cost limit per discharge. Thus, hospitals and units that are excluded from PPS do not know what their total Medicare payments will be until after their year-end cost reports have been settled.

Moreover, it is not feasible for fee-for-service FEHB plans to calculate Medicare payments rates for inpatient hospital services provided in PPS excluded hospitals and units. OPM and HCFA agree that the intent of section 7002(f) of OBRA '90 was not to have the fee-for-service FEHB plans perform year-end settlements of hospital cost reports to determine a hospital's TEFRA payments, which are hospital-specific as opposed to the patient-specific payments under PPS. Although it is feasible for a fee-for-service FEHB plan to compare prospective payments for a single beneficiary against a hospital's charges for that patient, it would not be feasible for a fee-for-service FEHB to compare the TEFRA limit to the charges for a specific patient that would in effect involve aggregating all individual patients' charges and then imposing the limits. Instead, HCFA and OPM agree that the intent of section 7002(f) of OBRA '90 is to establish Medicare payment limits on inpatient hospital charges in accordance with the payment rates established under sections 1886(d) and (g) of the Act.

We note that both OPM's interim final rule (published March 27, 1992, in the **Federal Register** at 57 FR 10609) and final rule (published July 20, 1993, in the **Federal Register** at 58 FR 38661) specify that limitations on inpatient hospital charges and FEHB program payments are based on Medicare's DRG equivalent payment amount (a rate that represents as closely as possible the amount that Medicare would have paid had a retired FEHB enrollee been covered under Medicare Part A). Again, because of the differences in the two payment systems (PPS and TEFRA) and the difficulty in comparing what Medicare would have paid for a particular patient in a TEFRA provider, both HCFA and OPM agree that section 7002(f) of OBRA '90 does not apply to inpatient hospital services provided in non-PPS hospitals and units.

Comment: One commenter stated that it has encountered a problem in receiving correct payment amounts for inpatient hospital services furnished to retired Federal workers age 65 and older who are enrolled in a fee-for-service FEHB plan and who do not have Medicare Part A benefits. The commenter expressed concern that payment rates for some hospitals have not been equal to Medicare payment rates for the same services, and that the payment rates used by OPM and the fee-for-service FEHB plans are not the most recent rates. The commenter recommended that the Medicare payment rates received by OPM and the fee-for-service FEHB plans be current and updated as of October 1 of each year when new DRG rates are known and technical corrections have been made. Two commenters also requested that the payment rates include all applicable adjustments to the DRG rate, such as the indirect medical education cost adjustment, payment for direct graduate medical education costs, outlier payments, inpatient capital costs, kidney acquisition costs, etc.

Response: OPM addressed a similar comment in its July 20, 1993 final rule (58 FR 38661). We agree with OPM's response, which stated that OPM and the FEHB plans intend to calculate the DRG equivalent amount as closely as possible to the amount that would have been paid by Medicare.

We have been working with OPM to provide the latest DRG payment rates. In fact, the data provided by HCFA to OPM for calculating the DRG equivalent payment amount include all applicable adjustments to the DRG rate, such as the indirect medical education cost adjustment, payment for direct graduate medical education costs, organ acquisition costs, capital costs, and outlier payments. Any dispute involving a payment made by a fee-for-service FEHB plan for inpatient hospital services provided to a retired Federal worker who is enrolled in the fee-for-service FEHB plan and who does not have Medicare Part A coverage should be resolved by the particular FEHB plan and the provider.

Medicare Grouper, Code Editor and Pricer software data provide current DRG payment data to OPM as of October 1 of each fiscal year. The Medicare fiscal intermediaries send HCFA a provider file every 3 months. The provider-specific file includes the data needed to calculate adjustments to the DRG rate, such as outlier payments, the indirect medical education cost adjustment, payment for direct graduate medical education costs, organ acquisition costs, and inpatient capital costs.

Because of a transition to a new capital payment system, capital cost data for 1992 were not available to the fee-for-service FEHB plans. The fee-for-service FEHB plans were advised by OPM to use ''pass-through'' information multiplied by the length of stay to determine an equivalent capital cost adjustment amount. Capital cost information has been available to the fee-for-service FEHB plans since the 1993 coverage year.

Comment: One commenter recommended that an appeal mechanism be put in place to resolve payment differences and ensure that

correct payments are made to providers. The same commenter suggested that a paid Medicare remittance for an identical DRG should be adequate documentation to ensure that a provider is being paid the correct amount, that is, the equivalent Medicare DRG payment amount.

Response: In its July 20, 1993 final rule, OPM stated that fee-for-service FEHB plans have an obligation to work with hospital providers to determine the correct payment amounts and to make any necessary adjustments. Any decision to implement an appeals mechanism would be at the discretion of OPM, since OPM administers the FEHB program. Therefore, whether or not a paid Medicare remittance for identical DRG constitutes acceptable documentation is a matter for OPM and the FEHB plans to decide.

III. Provisions of the Final Regulations

After further review of the regulation text set forth in the February 10, 1994 proposed rule, we believe that several changes are needed to improve clarity.

The proposed rule would have revised the introductory text of § 489.21 and adding a new paragraph (I). We have determined that the proposed language does not have the same context as the language in § 489.21, and § 489.21 does not have the same meaning as the intent of section 7002(f) of OBRA '90. The existing introductory paragraph in § 489.21 states that *providers agree not to charge* a beneficiary for any of the services listed in this section (which would have included the services listed in the proposed paragraph (I)). However, the intent of section 7002(f) of OBRA '90 is that a fee-for-service FEHB plan should not pay a provider for inpatient hospital services furnished to a retired FEHB enrollee age 65 or older who is without Medicare Part A hospital insurance, more than the amount that Medicare would have paid had the enrollee been covered under Part A, minus any enrollee deductibles or copayment. Therefore, we are withdrawing the proposed language change to the existing regulation text in § 489.21.

Instead, we are adding a new § 489.23, which will require a provider to accept, as payment in full, an amount that approximates the Medicare payment rate established under the inpatient hospital PPS for inpatient hospital services furnished to retired Federal workers age 65 or older who are enrolled in a fee-for-service FEHB plan and who do not have Medicare Part A benefits.

We also proposed to amend § 489.53 to specify that HCFA may terminate the Medicare provider agreement with any hospital that knowingly and willfully fails to accept, on a repeated basis, the Medicare payment rate established under PPS, minus any enrollee deductibles or copayments, as payment in full from a fee-for-service FEHB plan for inpatient services provided to retired Federal enrollees age 65 or older who do not have Medicare Part A benefits. In order to further clarify the proposed change, we are revising § 489.53(a)(13)(redesignated now as (a)(15)) to specify that the provision applies only to providers that furnish inpatient hospital services to retired Federal enrollees of fee-for-service FEHB plans who are 65 or older who do not have Medicare Part A benefits.

IV. Regulatory Impact Statement

HCFA has examined the impacts of this final rule as required by Executive Order 12866 and the regulatory Flexibility Act (Pub. L. 96–354). Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects; distributive impacts; and equity). The Regulatory Flexibility Act requires agencies to analyze options for regulatory relief for small businesses. Most hospitals, and most other providers are small entities, either by nonprofit status or by having revenues of $5 million or less annually.

This final rule requires a provider that furnishes inpatient hospital services to retired Federal workers age 65 or older who are enrolled in a fee-for-service FEHB plan but who are not covered under Medicare Part A hospital benefits to accept as payment in full an amount that approximates the Medicare payment rates established under the prospective payment system.

In addition, HCFA may terminate the Medicare provider agreement with any provider that knowingly and willfully fails to accept, on a repeated basis, an amount that approximates the Medicare rate established under the inpatient hospital prospective payment system, minus any health plan deductible or copayment, as payment in full from a fee-for-service FEHB plan, for inpatient hospital services provided to a retired Federal enrollee of the fee-for-service FEHB plan who does not have Medicare Part A benefits.

Section 7002(f) of OBRA '90 became effective January 1, 1992, without rulemaking. Because hospitals will not be able to charge what they would normally charge private pay patients and other commercial insurers, it is estimated that there will be a substantial savings, per affected enrollee, to the FEHB program. Hospitals have been notified of their obligations through OPM administrative procedures. Savings will accrue directly through the OPM program, and compliance will be obtained and monitored by OPM.

HCFA is involved only because the Congress required that we establish a sanction mechanism in case any hospitals knowingly and willfully violate the requirement on a repeated basis. These sanction procedures would come into play only after an OPM determination of a violation and notification to HCFA. Hospitals that do not charge more than an amount that approximates the hospital payments established for Medicare purposes would not be affected by this rule. We do not believe that any hospitals will knowingly refuse to comply, or that any hospital will lose provider status. Therefore, this final rule will have negligible economic effects.

Section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a final rule may have a significant impact on the operations of a substantial number of small rural hospitals. Such an analysis must conform to the provisions of section 603 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside a Metropolitan Statistical Area and has fewer than 50 beds. We are not preparing a rural hospital impact statement because we have determined, and we certify, that this final rule will not affect a significant number of small entities and will not have a significant economic impact on the operations of a substantial number of small rural hospitals.

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

List of Subjects in 42 CFR Part 489

Health facilities, Medicare, Reporting and recordkeeping requirements.

42 CFR part 489 is amended as set forth below:

PART 489—PROVIDER AND SUPPLIER AGREEMENTS

1. The authority citation for part 489 continues to read as follows:

Authority: Secs. 1102, 1861, 1864(m), 1866, and 1871 of the Social Security Act (42 U.S.C. 1302, 1395x, 1395aa(m), 1395cc, and 1395hh).

2. A new § 489.23 is added to read as follows:

§ 489.23 Specific limitation on charges for services provided to certain enrollees of fee-for-service FEHB plans.

A provider that furnishes inpatient hospital services to a retired Federal worker age 65 or older who is enrolled in a fee-for-service FEHB plan and who is not covered under Medicare Part A, must accept, as payment in full, an amount that approximates as closely as possible the Medicare inpatient hospital prospective payment system (PPS) rate established under part 412. The payment to the provider is composed of a payment from the FEHB plan and a payment from the enrollee. This combined payment approximates the Medicare PPS rate. The payment from the FEHB plan approximates, as closely as possible, the Medicare PPS rate minus any applicable enrollee deductible, coinsurance, or copayment amount. The payment from the enrollee is equal to the applicable deductible, coinsurance, or copayment amount.

3. In § 489.53, the introductory text to paragraph (a) is republished and a new paragraph (a)(14) is added to read as follows:

§ 489.53 Termination by HCFA.

(a) *Basis for termination of agreement with any provider.* HCFA may terminate the agreement with any provider if HCFA finds that any of the following failings is attributable to that provider:

* * * * *

(14) The hospital knowingly and willfully fails to accept, on a repeated basis, an amount that approximates the Medicare rate established under the inpatient hospital prospective payment system, minus any enrollee deductibles or copayments, as payment in full from a fee-for-service FEHB plan for inpatient hospital services provided to a retired Federal enrollee of a fee-for-service FEHB plan, age 65 or older, who does not have Medicare Part A benefits.

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(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance)

Dated: October 17, 1997.

Nancy-Ann Min DeParle,

Deputy Administrator, Health Care Financing Administration.

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FEDERAL COMMUNICATIONS COMMISSION

47 CFR Chapter I

[CC Docket No. 96–61; FCC 97–366]

Petition for Rulemaking to Reclassify AT&T Corp. as Having Dominant Carrier Status

AGENCY: Federal Communications Commission.

ACTION: Final rule.

SUMMARY: The Order on Reconsideration, Order Denying Petition for Rulemaking, and Second Order on Reconsideration in CC Docket No. 96–61 (Order) released October 9, 1997 finds no new evidence or arguments that demonstrate that a new examination of AT&T's regulatory status is warranted. The Order also finds no basis to impose on AT&T a service requirement not imposed on other carriers subject to the rate averaging and rate integration rules, and that the Commission properly included AT&T/Alascom within the scope of the reclassification of AT&T as non-dominant in the provision of interstate, domestic, interexchange services. Finally, the Order clarifies that, to the extent AT&T/Alascom has been found to be dominant in the provision of certain interstate common carrier services (which the Commission has previously defined as ''all interstate interexchange transport and switching services that are necessary for other interexchange carriers to provide services in Alaska up to the point of interconnection with each Alaska local exchange carrier.''), AT&T/Alascom's regulatory obligations with respect to those services remain unchanged.

EFFECTIVE DATE: November 28, 1997.

FOR FURTHER INFORMATION CONTACT: Christopher Heimann, Attorney, Common Carrier Bureau, Policy and Program Planning Division, (202) 418–1580. For additional information concerning the information collections contained in this Order contact Judy Boley at (202) 418–0214, or via the Internet at jboley@fcc.gov.

SUPPLEMENTARY INFORMATION: This is a summary of the Commission's Order adopted October 8, 1997, and released October 9, 1997. The full text of this Order is available for inspection and copying during normal business hours in the FCC Reference Center, 1919 M St., N.W., Room 239, Washington, D.C. The complete text also may be obtained through the World Wide Web, at http://www.fcc.gov/Bureaus/Common Carrier/Orders/fcc97–366.wp, or may be purchased from the Commission's copy contractor, International Transcription Service, Inc., (202) 857–3800, 1231 20th St., N.W., Washington, D.C. 20036.

SYNOPSIS OF ORDER ON RECONSIDERATION

I. Introduction

1. On October 23, 1995, the Commission issued an order granting AT&T Corporation's (AT&T's) motion to be reclassified as a non-dominant carrier under Part 61 of the Commission's rules and regulations. On November 22, 1995, the State of Hawaii (Hawaii) and General Communications, Inc. (GCI) timely filed Petitions for Reconsideration of the Commission's *AT&T Reclassification Order.* For the reasons stated below, we deny the petitions of both Hawaii and GCI.

2. On January 23, 1996, more than two months past the statutory deadline, Total Telecommunications Services, Inc. (TTS) also filed a Petition For Reconsideration, and a Motion For Acceptance of Petition For Reconsideration. As discussed below, we deny TTS's motion and dismiss its petition as untimely, and therefore do not address the merits of its petition.

3. On December 23, 1996, GCI filed a Petition for Reconsideration or Clarification of the Commission's *Tariff Forbearance Order* (61 FR 59340 (November 22, 1996)). For the reasons discussed below, we grant GCI's petition for clarification of the *Tariff Forbearance Order.*

4. Finally, on December 31, 1996, the United Homeowners Association and the United Seniors Health Cooperative (UHA), filed a Petition for Rulemaking to Reclassify AT&T as Having Dominant Carrier Status. For the reasons discussed below, we deny UHA's petition.

II. Petitions for Reconsideration

A. Background

5. In the *AT&T Reclassification Order,* the Commission reclassified AT&T as a non-dominant carrier, based on the Commission's finding that AT&T no longer possessed individual market power in the interstate, domestic, interexchange market taken as a whole. The Commission acknowledged that there was evidence in the record that AT&T, MCI and Sprint had increased basic schedule rates in lock-step, but found that that evidence did not support a finding that AT&T retained the power unilaterally to raise residential prices above competitive levels. In addition, the Commission found that, to the extent that tacit price coordination with respect to basic schedule or residential rates in general was occurring, the problem was generic to the