[FR Doc. 96–22377 Filed 8–30–96; 8:45 am]
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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Part 417

[OMC–010–FC]

RIN 0938–AF74

Medicare and Medicaid Programs; Requirements for Physician Incentive Plans in Prepaid Health Care Organizations

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

ACTION: Final rule correction; Notice of changes in compliance dates, with comment period.

SUMMARY: In the March 27, 1996, issue of the Federal Register, we published, at 61 FR 13430, a final rule with comment period that implements requirements in sections 4204(a) and 4731 of the Omnibus Budget Reconciliation Act of 1990 that concern physician incentive plans. In the preamble of that rule, we set forth dates by which prepaid health plans had to comply with certain of the rule's provisions. This document clarifies and changes some of those deadlines, and provides an opportunity for public comments on them. It does not otherwise change the requirements set forth in the rule.

In addition this document corrects the March 27 rule's inadvertent reversal of the nomenclature change made by a previous final rule.

DATES: *Effective date:* September 3, 1996.

Comment dates: Comments on the decision to change the compliance dates published in the March 27, 1996 preamble will be considered if received at the appropriate address provided below, no later than 5 p.m. on November 4, 1996.

ADDRESSES: Mail written comments (1 original and 3 copies) to the following address: Health Care Financing Administration, Department of Health and Human Services, Attention: OMC–010–CN, P.O. Box 26688, Baltimore, MD 21207.

If you prefer, you may deliver your written comments (1 original and 3 copies) to one of the following addresses: Room 309–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201, or Room C5–09–26, 7500 Security Boulevard, Baltimore, MD 21244–1850.

Because of staffing and resource limitations, we cannot accept comments by facsimile (FAX) transmission. In commenting, please refer to file code OMC–010–CN. 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: Medicare: Tony Hausner, (410) 786–1093. Medicaid: Beth Sullivan, (410) 786–4596.

SUPPLEMENTARY INFORMATION:

I. Change in Compliance Dates

The preamble for the March 27, 1996, rule (61 FR 13430) stated that the regulation was effective on April 26, 1996. The preamble also set forth a set of ''compliance dates,'' by which times the prepaid health plans affected by the regulation would be required to have taken actions to be in compliance with the regulation. These dates varied, depending on the specific requirements of the regulations. They also varied depending on whether the prepaid health plan had a contract with Medicare or Medicaid in place on March 27, 1996, or entered into its initial contract at a later date.

These compliance dates ranged from a date certain—May 28, 1996—to a date determined by when the prepaid health plan applied for a contract, renewed an existing contract, or took other actions specified in the regulation. For example, most of the requirements that prepaid health plans disclose specified elements of information to us would become applicable by May 28, 1996, or by the renewal date of the plan's contract with us, whichever is later. Since all Medicare risk contracts with prepaid health plans are put on a January 1 renewal cycle, this meant that, for practical purposes, these requirements would all become effective on January 1, 1997.

The explanation of these compliance dates in the March 27, 1996, preamble, however, was not sufficiently comprehensive and unambiguous to be fully understood. There has been considerable confusion, doubt, and misunderstanding about them, particularly with respect to their applicability to new contracts entered into subsequent to March 27, 1996. It is also now apparent that some of the compliance dates were clearly impracticable. Most notably, the regulation requires plans, under certain circumstances, to obtain ''stop-loss'' insurance; the compliance date set forth for doing so was May 28, 1996. This was not only unrealistic, but it was also inconsistent with the related disclosure requirements that would not go into effect until January 1, 1997, and with the wording in the congressional authorizing legislation stating that the law should become effective with the start of a contract year. We notified prepaid health plans on May 28 that this requirement would not be enforced before January 1, 1997.

Because of these difficulties with the compliance dates set forth in the March 27 publication, we have decided to simplify and clarify all of the compliance dates. Stated in general terms, the compliance date for all provisions (other than the two exceptions noted below) is now the first renewal date falling on or after January 1, 1997, or the effective date of a new contract or agreement having an effective date on or after January 1, 1997. To explain how this statement applies to contracts and agreements having various renewal dates or effective dates, and how it applies differently to Medicare contracts and to Medicaid contracts or agreements, we provide the following details:

- For all affected health maintenance organizations (HMOs), competitive medical plans (CMPs), and health insuring organizations (HIOs) that have contracts or agreements with HCFA or State Medicaid Agencies in effect on the date of this notice, the March 27, 1996, regulation becomes applicable (according to the terms set forth in the regulation) at the time the contract or agreement is next renewed on or after January 1, 1997. For all plans with Medicare risk contracts, this means the compliance date is January 1, 1997, since that is uniformly the renewal date for all risk contracts. That is also the renewal date for the majority of Medicare cost contracts, although there are a few for which the renewal date will occur later in 1997, at which time this regulation becomes applicable to them. Medicaid agreements have varying dates for renewal and some of them are written as multi-year agreements. For Medicaid agreements, compliance is required for all plans at a date during calendar year 1997. That date is the date on which the agreement is renewed or, in the case of multi-year agreements, the anniversary date of the effective date of the agreement.
- For all affected HMOs and CMPs that enter into Medicare contracts between the date of this notice and the end of calendar year 1996, the

compliance date is January 1, 1997. For HMOs and HIOs entering into Medicaid contracts or agreements during this period, the regulation becomes applicable on the first anniversary date in 1997 of the effective date of their contract or agreement.

- For all affected HMOs, CMPs, and HIOs that enter into contracts or agreements on or after January 1, 1997, whether for Medicare or Medicaid, the regulation becomes applicable on the effective date of the contract or agreement.

There are two exceptions to the general rule set forth above:

- The requirement in § 417.479(g)(1) that surveys be conducted of plan enrollees and disenrollees under specified circumstances must be met within 1 year of the compliance date for the plan in question, as set forth above. This allows affected HMOs, CMPs, and HIOs discretion on the timing of the survey and permits them to combine it with a survey they may already be conducting and to survey all the enrollees in their sample at the same time.
- The requirement in § 417.479(h)(1)(vi) that plans disclose capitation payments for the most recent year must be met, by all plans with contracts or agreements in effect on December 31, 1996, by April 1, 1997, disclosing information for calendar year 1996. Plans with new agreements on or after January 1, 1997, must comply by April 1 of the first year after the year of the effective date, disclosing data for the calendar year of the effective date.

II. Other Provisions of the March 27 Regulation

This document does not address any of the requirements set forth in the March 27, 1996, final rule other than the compliance dates. All of the obligations of prepaid plans set forth in the regulation remain intact. The March 27, 1996, rule provided a 60-day opportunity for comment. We have received a variety of comments in response to it. We will be publishing a document in the Federal Register later, evaluating and responding to these comments. In the meantime, prepaid plans affected by this regulation should be making arrangements to comply with the requirements as set forth on March 27, in accordance with the compliance dates established in this document.

III. Technical Corrections in Nomenclature

The March 27 rule inadvertently reversed a nomenclature change that a previous final rule identified as OCC–015 (published on July 15, 1993, at 58 FR 134) had made throughout part 417. This document corrects the oversight by restoring the precise terms ''HMO'' and ''CMP'' that are currently used throughout part 417 instead of the generic ''organization''.

IV. Waiver of Prior Notice and Comment

Changes in final regulations are ordinarily published in proposed form to provide for a period of public comment prior to the change taking effect. However, we may waive this procedure if we find good cause that prior notice and comment are impractical, unnecessary, or contrary to public interest. We find good cause to implement the changes made in this notice without prior notice and comment because the delay in prior notice and comment would be impractical and contrary to the public interest. As set forth above, we do not believe that it would be reasonable to expect HMOs, CMPs, and HIOs to be in compliance with the requirements that the final rule indicated these entities were required to comply with by May 28, 1996. We have already communicated with affected entities the fact that we were planning to publish a notice changing these compliance dates and would not take enforcement actions under the regulations pending this change. We believe that it is not in the public interest for regulatory compliance obligations to be imposed under a timeframe that both the entities affected and we believe to be unreasonable and impractical. Given the fact that some of these compliance obligations have already taken effect, we believe that it would be impractical to leave these obligations in place pending a public notice and comment process.

Corrections

§ 417.479 [Corrected]

1. On page 13446, column 3, in § 417.479(a) introductory text, ''organization'' is revised to read ''HMO or CMP''.

2. On page 13447, column 1, in paragraph (b), ''eligible organizations'' is revised to read ''HMOs and CMPs''; in the definitions in paragraph (c) of ''bonus'', ''payments'', and ''physician incentive plan'', ''organization'', wherever it appears, is revised to read ''HMO or CMP'', and in the definition of ''payments'', ''this subpart'' is revised to read ''this section''.

3. On page 13447, column 2, in the definition of ''withhold'', ''organization'' is revised to read ''HMO or CMP'', and in paragraph (d), ''organization's'' is revised to read ''HMO's or CMP's''.

4. On page 13447, column 3, in paragraph (g) introductory text, ''organizations'' is revised to read ''HMOs and CMPs'', and in paragraph (g)(1)(i), ''organization'' is revised to read ''HMO or CMP'', and ''organization's'' is revised to read ''HMO's or CMP's''.

5. On page 13448, column 1, in paragraph (g)(2)(ii) introductory text and paragraph (g)(2)(iii), ''organization'', wherever it appears, is revised to read ''HMO or CMP'', and in paragraphs (h)(1) introductory text and (h)(1)(v)(B), ''organization'' is revised to read ''HMO or CMP''.

6. On page 13448, column 2, in paragraphs (h)(2)(i) introductory text, (h)(2)(ii) introductory text, (h)(3) introductory text, and paragraph (i)(1) introductory text, ''organization'' is revised to read ''HMO or CMP''.

7. On page 13448, column 3, in paragraph (i)(2) introductory text, and the heading of paragraph (j), ''organization'' is revised to read ''HMO or CMP'', and in the text of paragraph (j), ''eligible organization'' is revised to read ''HMO or CMP''.

(Catalog of Federal Domestic Assistance Program No. 93.733—Medicare—Hospital Insurance Program; No. 93.774—Medicare Supplementary Medical Insurance Program; No. 93.778—Medical Assistance Program)

Dated: August 4, 1996.

Bruce C. Vladeck,

Administrator, Health Care Financing Administration.

Dated: August 14, 1996.

Donna E. Shalala,

Secretary.

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DEPARTMENT OF TRANSPORTATION

National Highway Traffic Safety Administration

49 CFR Part 583

[Docket No. 92–64; Notice 9]

RIN 2127–AG46

Motor Vehicle Content Labeling

AGENCY: National Highway Traffic Safety Administration (NHTSA), Department of Transportation (DOT).

ACTION: Temporary final rule; Request for comments.

SUMMARY: Under NHTSA's content labeling program, passenger motor vehicles (passenger cars and other light vehicles) are required to be labeled with