

- In § 422.202(a)(4), we corrected a cross-reference.
- In § 422.210, we revised paragraph (a) to reflect changes to the reporting requirements concerning physician incentive plans.
- In § 422.250, we revised paragraph (a)(1) to reflect that, beginning with the initial payment for CY 2003, monthly payments to M+C organizations may be reduced by the amount described in new § 422.312(d) for the reduction of the beneficiary's standard Part B premium.
- In § 422.250, we also revised paragraph (a)(2) to redesignate paragraph (a)(2)(i)(B) as (a)(2)(i)(C) and to add new paragraph (a)(2)(i)(B) to reflect that, when we establish ESRD rates, we will apply appropriate adjustments, including risk adjustment factors.
- In § 422.256, we revised paragraph (b) to reflect that we will make appropriate payment adjustments for new benefits covered during a contract term due to NCDs and legislative changes in benefits that result in a significant increase in costs to M+C organizations, based on an analysis by our chief actuary. We also revised this section to reflect that we will apply a "NCD adjustment factor" in calculating rates for counties receiving the two percent minimum update. This factor will represent the percent of total Medicare cost attributed to the aggregate costs of all NCDs and legislative changes in benefits in the previous year.
- In § 422.266, we revised paragraph (c) to clarify that when enrollees of M+C plans elect to receive hospice care under § 418.24, we will not make any payment for the hospice care to the M+C plan beginning with the next month's payment after the election, except for the portion of the payment applicable to additional benefits, as described in § 422.312.
- In § 422.312, we redesignated paragraph (d) as paragraph (e) and added new paragraph (d) to reflect that an M+C organization may apply adjusted excess amounts to additional benefits and accept lower payments from us, which would allow a reduction of standard Part B premiums for its enrollees. The reduction in standard Part B premiums could not equal more than 80 percent of the reduction in payments to the M+C organization and the payment reduction could not exceed 125 percent of the standard Part B premium. In addition, the reduction in premium would have to be applied uniformly to all similarly situated enrollees.
- We added new § 422.521 to indicate that we will not implement, other than

at the beginning of a calendar year, requirements that would impose new cost or burden on M+C organizations or plans, unless a different effective date is required by statute.

- In § 422.566, we revised paragraph (c) to delete the cross-reference to § 422.574 and to delineate who can request an organization determination.
- In § 422.618, we revised paragraph (c) to add an effectuation exception when the M+C organization files an appeal with the DAB in the case of a standard reconsidered determination.
- In § 422.619, we revised paragraph (c) to add an effectuation exception when the M+C organization files an appeal with the DAB in the case of an expedited reconsidered determination.
- In § 422.758, we revised paragraph (b) to include the new maximum amount of the civil money penalties that we would impose on M+C organizations that terminate their contracts in a manner other than that described in § 422.512. The new penalty amount will be \$100,000 or \$250 per Medicare enrollee from the terminated plan or plans, whichever is greater.

IV. Waiver of Proposed Rulemaking

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** and invite public comment on revisions to regulations. The notice of proposed rulemaking includes a reference to the legal authority under which the rule is proposed, and the terms and substances of the proposed rule or a description of the subjects and issues involved. We followed this procedure with respect to all but one of the regulatory revisions made in this final rule. As noted above, the proposed rule did not include the revision to § 422.152(f) that we are making in this final rule that adds a new paragraph (4) reflecting the provisions of section 616 of the BIPA. The requirement that we issue regulations in proposed form for public comment can be waived, however, if an agency finds good cause that notice and comment procedures are impracticable, unnecessary, or contrary to the public interest, and it incorporates a statement of the finding and its reasons in the rule issued.

We find that publishing the new paragraph (4) in § 422.152(f) in proposed form is unnecessary, because this provision only revises the regulations text to reflect the provisions of section 616 of the BIPA, and has no legal effect. These provisions were enacted by the Congress, and took effect on the date mandated by the legislation without regard to whether they are reflected in conforming changes to the regulation text. In the new

§ 422.152(f)(4), we merely have revised the regulation text to reflect section 616. Therefore, we do not believe that publishing a notice of proposed rulemaking is necessary and we find good cause to waive the notice of proposed rulemaking and to issue this final rule.

V. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995 (PRA), we are required to provide 30-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the PRA requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

Section 417.479(h)—Physician Incentive Plans. In this final rule, we require HMOs to provide us, upon request, information concerning its physician incentive plans. HMOs are also required to provide this information to any Medicare beneficiary who requests it. While this requirement is subject to the PRA, the burden associated with this requirement is captured in approved collection 0938–0700.

Section 422.50(a)(2)—In this final rule, this section states that an individual who develops end-stage renal disease while enrolled in an M+C plan or in a health plan offered by an M+C organization is eligible to elect an M+C plan offered by that organization. Also, an individual with end-stage renal disease whose enrollment in an M+C plan is terminated or discontinued after December 31, 1998 because we or the M+C organization terminated the M+C organization's contract for the plan or discontinued the plan in the area in which the individual resides is eligible to elect another M+C plan. An individual who elects an M+C plan under paragraph (a)(2)(ii) of this section may elect another M+C plan if the plan elected under paragraph (a)(2)(ii) also is terminated or discontinued in the area in which the individual resides.