

NCDs in this rule adds approximately \$48 million per year to the Federal budget.

The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and government agencies. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status, or by having revenues of between \$6 million and \$29 million or less annually. (For details, see the Small Business Administration publication that sets forth size standards for health care industries at 65 FR 69432.) Individuals and States are not included in the definition of small entities.

For purposes of the RFA, most managed care organizations are not considered to be small entities. We estimate that fewer than 5 out of 177 M+C organization contractors have annual revenues of \$7.5 million or less. Approximately 35 percent of M+C organization contractors have tax-exempt status, and thus, for purposes of the RFA, are considered to be small entities. We have examined the economic impact of this final rule on M+C organizations, including those that are tax-exempt, and, therefore, small entities. We find that overall the economic impact is positive, due to the revised ESRD rates mandated by section 605 of the BIPA, which are generating an increase in payments; the increase in payments due to the revised policy on NCDs, and the reductions in regulatory burden due to the premium reductions in section 606, the waivers of M+C rules specified in section 606 for employers and related organizations, the waiver of the 3 day hospital stay for SNF admissions, and the reduction of the physician incentive reporting requirements. Therefore, we certify that this final rule will not have a significant impact on a substantial number of small businesses. The data available do not allow us to determine the distributional effects of this increase. We have not considered alternatives to lessen the economic impact or regulatory burden of this final rule because the regulatory burden is reduced and payment to the plans is increased by this rule. The major change between the proposed and final rule is the method for computing a significant national coverage determination. This change will have a net benefit to M+C organizations. We certify that this final rule will not have a significant impact on a substantial number of small entities.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a final rule has a

significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 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 of a Metropolitan Statistical Area (MSA) and has fewer than 100 beds. Almost 2 percent of M+C enrollees reside in payment areas outside MSAs. Because information on the payment terms in contracts between M+C organizations and their providers is not available, data are not available on the level of this economic impact.

B. The Unfunded Mandates Act

Section 202 of the Unfunded Mandates Reform Act of 1998 (UMRA) requires that agencies assess anticipated costs and benefits before issuing any rule that may result in an expenditure in any 1 year by State, local, or tribal governments, in the aggregate, or by the private sector, of \$110 million. We have determined, and we certify that this final rule has no consequential effect on State, local, or tribal governments.

C. Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed or final rule that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. This final rule will impose no direct requirement costs on State and local government, will not preempt State law, or have any Federalism implications.

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

List of Subjects

42 CFR Part 409

Health facilities, Medicare.

42 CFR Part 417

Administrative practice and procedure, Grants programs-health, Health care, Health insurance, Health maintenance organizations (HMO), Loan programs-health, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 422

Administrative practice and procedure, Health facilities, Health Maintenance Organizations (HMO), Medicare+Choice, Penalties, Privacy, Provider-sponsored organizations (PSO), Reporting and recordkeeping requirements.

■ For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services amends 42 CFR chapter IV as set forth below:

PART 409—HOSPITAL INSURANCE BENEFITS

■ 1. The authority citation for part 409 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

Subpart C—Posthospital SNF Care

■ 2. In § 409.20, the following amendments are made as set forth below:

- a. Paragraph (c)(3) is revised.
- b. Paragraph (c)(4) is added.

§ 409.20 Coverage of services.

* * * * *

(c) * * *

(3) The term *swing-bed hospital* includes a CAH with swing-bed approval under subpart F of part 485 of this chapter.

(4) The term *post-hospital SNF care* includes SNF care that does not follow a hospital stay when the beneficiary is enrolled in a plan, as defined in § 422.4 of this chapter, offered by a Medicare+Choice (M+C) organization, that includes the benefits described in § 422.101(c) of this chapter.

Subpart D—Requirements for Coverage of Posthospital SNF Care

■ 3. In § 409.30, paragraph (b)(2) is revised to read as follows:

§ 409.30 Basic requirements.

* * * * *

(b) * * *

(2) The following exceptions apply—

(i) A beneficiary for whom posthospital SNF care would not be medically appropriate within 30 days after discharge from the hospital or CAH, or a beneficiary enrolled in a Medicare+Choice (M+C) plan, may be admitted at the time it would be medically appropriate to begin an active course of treatment.

(ii) If, upon admission to the SNF, the beneficiary was enrolled in an M+C plan, as defined in § 422.4 of this chapter, offering the benefits described in § 422.101(c) of this chapter, the beneficiary will be considered to have met the requirements described in paragraphs (a) and (b) of this section, and also in § 409.31(b)(2), for the duration of the SNF stay.

■ 4. In § 409.31 paragraph (b)(2)(ii) is revised, and a new paragraph (b)(2)(iii) is added to read as follows: