if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more annually). We have determined that this notice is not a major rule because it does not impose a significant economic impact to preferred provider organizations or the Medicare program.

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. For purposes of the RFA, most preferred provider organizations are considered to be small entities, either by nonprofit status or by having revenues of $6 to $29 million or less annually. (For details, see the Small Business Administration's regulation that set forth size standards for health care industries (65 FR 69432).) The criteria described in this notice will not significantly impact the ESRD Network Organizations that are considered small entities because the notice reflects what is already being done. Individuals and States are not included in the definition of a small entity.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a notice may have 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 and has fewer than 100 beds.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule that may result in expenditure in any 1 year by State, local, or tribal governments, in the aggregate, or by the private sector, of $110 million. This notice will not mandate any requirements for State, local, or tribal governments.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a notice with comment that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. We have reviewed this notice under these requirements and have determined that it will not impose substantial direct requirement costs on State or local governments.

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

Authority: Section 1881 of the Social Security Act (42 U.S.C. 1395rr).

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

Dated: December 19, 2001.

Thomas A. Scully,

Administrator, Centers for Medicare & Medicaid Services.

Editorial note: This document was received at the Office of the Federal Register June 25, 2002.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–1198–NC]

RIN 0938–AL16

Medicare Program; Update to the Prospective Payment System for Home Health Agencies for FY 2003

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Notice with comment period.

SUMMARY: This notice with comment period sets forth an update to the 60-day national episode rates and the national per-visit amounts under the Medicare prospective payment system for home health agencies.

DATES: *Effective Date:* The rate updates in this notice with comment period are effective on October 1, 2002.

Comment Period: We will consider comments if we receive them at the appropriate address, as provided below, no later than 5 p.m. on August 27, 2002.

ADDRESSES: In commenting, please refer to file code CMS–1198–NC. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission. Mail written comments (one original and three copies) to the following address only: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1198–NC, P.O. Box 8016,Baltimore, MD 21244–8016.

Please allow sufficient time for mailed comments to be timely received in the event of delivery delays.

If you prefer, you may deliver (by hand or courier) your written comments (one original and three copies) to one of the following addresses:

Room 443–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201, or Room C5–14–03, 7500 Security Boulevard,Baltimore, MD 21244–1850.

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and could be considered late.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT: Susan Levy, (410) 786–9364; Chester Robinson, (410) 786–6959

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone (410) 786–7197.

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I. Background

Payment to Home Health Agencies

A. Balanced Budget Act of 1997

The Balanced Budget Act of 1997 (BBA), Public Law 105–33, enacted on August 5, 1997, significantly changed the way Medicare pays for Medicare home health services. Until the implementation of a home health

prospective payment system (HH PPS) on October 1, 2000, home health agencies (HHAs) received payment under a cost-based reimbursement system. Section 4603 of the BBA governed the development of the HH PPS by adding section 1895 to the Social Security Act (the Act).

B. System for Payment of Home Health Services

Generally, Medicare makes payment under the home health prospective payment system on the basis of a national standardized 60-day episode payment, adjusted for case-mix and wage index. For episodes with four or fewer visits, Medicare pays on the basis of a national per-visit amount by discipline, referred to as a low utilization payment adjustment (LUPA). Medicare also adjusts the 60-day episode payment for certain intervening events that give rise to a partial episode payment (PEP) adjustment or a significant change in condition (SCIC) adjustment. For certain cases that exceed a specific cost threshold, an outlier adjustment may also be available. For a complete and full description of the home health prospective payment system as required by the BBA and as refined by the Omnibus Consolidated and Emergency Supplemental Appropriations Act (OCESAA) for FY 1999, Pub. L. 105–277, enacted on October 21, 1998, and the Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 1999 (BBRA), Public Law 106–113, enacted on November 29, 1999, see the July 3, 2000 HH PPS final rule (65 FR 41128).

C. Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000

Section 1895(b)(3)(A)(i)(III) of the Act, as redesignated by section 501 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), Public Law 106–554, enacted on December 21, 2000, delays until FY 2003 the application of the 15 percent reduction on the interim payment limits for home health services as applied to the home health prospective payment rates required by earlier legislation. Section 501 of BIPA also amends section 302(c) of the BBRA, to now require a report to the Congress by the Comptroller General of the United States no later than April 1, 2002 on the 15 percent reduction issue.

Section 502 of the BIPA sets forth a special rule for payment for FY 2001 based on adjustment of the published prospective payment amounts. This special payment rule has the effect of restoring the market basket reduction already incorporated into the home health prospective payment system (HH PPS) rates. The adjustment provides the effect of a full market basket adjustment to the HH PPS rates for FY 2001. The statute also requires paying episodes and national per-visit amounts for low utilization payment adjustments (LUPAs) ending on or after April 1, 2001 and before October 1, 2001 an additional 2.2 percent.

Section 508 of the BIPA also requires, for home health services furnished in a rural area (as defined in section 1886(d)(2)(D) of the Act) on or after April 1, 2001 and before April 1, 2003, that the Secretary increase the payment amount otherwise made under section 1895 of the Act for the services by 10 percent. The statute waives budget neutrality for purposes of this increase since it specifically states that the Secretary not reduce the standard prospective payment amount (or amounts) under section 1895 of the Act applicable to home health services furnished during a period to offset the increase in payments resulting in the application of this section of the statute.

II. Analysis of and Responses to Comments on the Home Health Prospective Payment System June 29, 2001 Notice With Comment Period

On June 29, 2001, we published a notice with comment period in the **Federal Register** (66 FR 34687) that set forth an update to the 60-day national episode rates and the national per-visit amounts under the Medicare prospective payment system for home health agencies (HHAs) for FY 2002. In this section, we respond to the two public comments that we received on the FY 2002 HH PPS:

Comment: Commenters recommended that we use the hospital wage index with consideration of statutorily established floors and administratively determined classifications. Further the commenter asked that the wage index used in determining the home health payment rate should be the same hospital wage index used and published for hospitals during the same fiscal year.

Response: As we have explained in the June 29, 2001 notice with comment period, we believe the use of the most recent available pre-floor and pre-reclassified hospital wage index data results in the appropriate adjustment to the labor portion of the costs as required by statute. By statute, the hospital wage index is adjusted to account for geographic reclassification of hospitals. The geographic reclassification applies only to hospitals. In addition, the hospital wage index has specific floors that are required by statute and apply only to hospitals. Because these reclassifications and floors do not apply to HHAs, we use the most recent available pre-floor and pre-classified hospital wage index data to adjust the home health payment rates. We recognize that the pre-floor and pre-classified hospital wage index differs slightly from the numbers published in the Medicare inpatient hospital prospective payment system (PPS) regulations but note that the wage indices published in the July 3, 2000 HH PPS final rule and subsequent annual updates reflect the most recent available pre-floor and pre-classified hospital wage index available at the time of publication.

Comment: Commenters suggested that we recalculate the base HH PPS rates to incorporate a different assumption than the published assumption of the 5 percent low utilization payment adjustment episodes in the base year of HH PPS. The commenters believe the recalculation should be characterized as an error on the face of the original calculation rather than viewed as a rebasing.

Response: In establishing the payment unit for HH PPS, including the 5 percent low utilization payment adjustment episode, we used the best available data in determining the payment rates for the base year for HH PPS. The statute provides for an annual update of the HH PPS payment rates. The statute does not contemplate a recalculation of the initial base year after the rates are established. We further note that the statute provides for a limitation on review of the HH PPS, in particular the establishment of the payment unit and the computations of the initial standardized prospective payment amounts.

III. Provisions of this Notice with Comment Period

A. National Standardized 60-Day Episode Rate

Medicare HH PPS has been effective since October 1, 2000. As set forth in the final rule published July 3, 2000 in the **Federal Register** (65 FR 41128), the unit of payment under Medicare HH PPS is a national standardized 60-day episode rate. As set forth in the July 3, 2000 final rule at 42 CFR 484.220, we adjust the national standardized 60-day episode rate by case-mix and wage index based on the site of service for the beneficiary. The FY 2003 HH PPS rates use the same case-mix methodology and application of the wage index adjustment to the labor portion of the HH PPS rates as set forth in the July 3, 2000 final rule. We multiply the national 60-day episode

rate by the patient's applicable case-mix weight. We divide the case-mix adjusted amount into a labor and nonlabor portion. We multiply the labor portion by the applicable wage index based on the site of service of the beneficiary. The labor portion of the rate continues to be .77668 and the nonlabor portion of the rate continues to be .22332. We add the wage adjusted portion to the nonlabor portion yielding the case-mix and wage adjusted 60-day episode rate subject to applicable adjustments.

For FY 2003, we use again the design and case-mix methodology described in section III.G of the July 3, 2000 HH PPS final rule (65 FR 41192 through 41203). For FY 2003, we base the wage index adjustment to the labor portion of the PPS rates on the most recent pre-floor and pre-reclassified hospital wage index available at the time of publication of this notice, which is discussed in section III.D of this notice with comment period.

As discussed in the July 3, 2000 HH PPS final rule, for episodes with four or fewer visits, Medicare pays the national per-visit amount by discipline, referred to as a LUPA. We update the national per-visit amounts by discipline annually by the applicable home health market basket. We adjust the national per-visit amount by the appropriate wage index based on the site of service for the beneficiary as set forth in § 484.230. We adjust the labor portion of the updated national per-visit amounts by discipline used to calculate the LUPA by the most recent pre-floor and pre-reclassified hospital wage index available at the time of publication of this notice, as discussed in section III.D of this notice with comment period.

As outlined in the July 3, 2000 HH PPS final rule, Medicare pays the 60-day case-mix and wage adjusted episode payment on a split percentage payment approach. The split percentage payment approach includes an initial percentage payment and a final percentage payment as set forth in § 484.205(b)(1) and (b)(2). We may base the initial percentage payment on the submission of a request for anticipated payment and the final percentage payment on the submission of the claim for the episode, as discussed in regulations in § 409.43. The claim for the episode that the HHA submits for the final percentage payment determines the total payment amount for the episode and whether we make an applicable adjustment to the 60-day case-mix and wage adjusted episode payment. The end date of the 60-day episode as reported on the claim determines the rate level at which Medicare will pay the claim for the fiscal period.

As discussed in the July 3, 2000 HH PPS final rule, we may adjust the 60-day case-mix and wage adjusted episode payment based on the information submitted on the claim to reflect the following:

- A low utilization payment provided on a per-visit basis as set forth in § 484.205(c) and § 484.230.
- A partial episode payment adjustment as set forth in § 484.205(d) and § 484.235.
- A significant change in condition adjustment as set forth in § 484.205(e) and § 484.237.
- An outlier payment as set forth in § 484.205(f) and § 484.240.

This notice with comment period reflects the updated national 60-day episode rate, the national per-visit amounts used to calculate the LUPA, and imputed costs for the outlier payment for FY 2003 that are effective October 1, 2002.

B. FY 2003 Update to the Home Health Market Basket Index

Section 1895(b)(3)(B)(ii) of the Act requires the standard prospective payment amounts to be increased by a factor equal to the home health market basket minus 1.1 percentage points for FY 2003. This has been codified in regulations in § 484.225.

- *FY 2003 Adjustments*

In calculating the annual update for the FY 2003 60-day episode rates, we first looked at the FY 2002 rates as a starting point. The FY 2002 national 60-day episode rate is $2,274.17. Second, we took into account section 501 of BIPA.

As stated in the background section of this update notice, section 501 of BIPA revised the statute to require the application of the 15 percent reduction on payment limits under the interim payment system (IPS), which is no longer in effect for home health services, for FY 2003. This statutory provision required an estimation of what Medicare spending would have been in FY 2001 if the IPS were still in effect and its limits reduced by 15 percent updated to FY 2003 in determining the HH PPS rates. It is important to note that HH PPS, not the interim payment system, has been in effect since October 1, 2000. Originally, the Balanced Budget Act of 1997 (BBA), Public Law 105–33, enacted on August 5, 1997, statutory language required the base year PPS rates to be budget neutral to what we would have paid under the IPS if the per-beneficiary and per-visit limits had been reduced by 15 percent. At the time of the BBA, when HHAs were paid the lower of their actual costs or the cost limits, most HHAs were paid at their limits. Absent any behavioral offset, lowering the IPS limits by 15 percent would have resulted in a straight reduction of 15 percent of Medicare spending for home health services.

At the time the BBA was enacted, we believed that the industry would eventually alter their behavior to avoid reaching the cost limits, and therefore upon implementation of the 15 percent reduction, not all HHAs would reach the level of the limits as reduced. We believed that the industry would respond to the reduced limits by increasing the number of low-cost beneficiaries served, thereby increasing the costs and decreasing the effect of the limits.

As a result of this anticipated behavior, we determined that the level by which actual payments would be reduced by lowering the limits would not be the same as the percent by which the limits themselves would be lowered. That is, the application of the 15 percent reduction in cost limits would lead to a 7 percent reduction in aggregate home health spending, hence, equivalently a 7 percent reduction in HH PPS payments. The statute requires us to look at the 15 percent reduction to the IPS limits updated to FY 2003. In determining how to calculate and implement the HH PPS rates using the required 15 percent reduction in cost limits, we still believe the HHAs would have altered their behavior to avoid reaching the limits. Thus, we retain our assumptions that result in the 7 percent reduction in overall payments. Based on the latest available reliable date, our best estimate is that a 15 percent reduction in cost limits would result in a 7 percent reduction in aggregate home health spending and, therefore, equivalently a 7 percent reduction on home health spending.

Accordingly, we calculate the FY 2003 HH PPS rates by first reducing the FY 2002 HH PPS rates by 7 percent. That amount is updated by the applicable home health market basket increase minus 1.1 percentage points, as required by the statute. It is important to note that Medicare home health payments are projected to continue to grow, even with the effect of the 15 percent reduction to the IPS limits. Under President Bush's FY 2003 budget, which assumes no further delays in the reduction, Medicare's total home health spending is projected to increase 12.2 percent in FY 2003, 8.3 percent in FY 2004, and 7.4 percent in FY 2005.

In order to calculate the FY 2003 national 60-day episode rate, the FY 2002 national 60-day episode rate ($2,274.17) is multiplied by .93 to take into account section 501 of BIPA. The annual update for FY 2003 is the home

health market basket minus 1.1 percentage points as defined in section 1895(b)(3)(B)(ii) of the Act. The home health market basket increase for FY 2003 is 3.2 percent. The previous amount is increased by the FY 2003 home health market basket increase minus 1.1 percentage points (2.1 percent) to yield the updated FY 2003 national 60-day episode rate ($2,159.39).

NATIONAL 60-DAY EPISODE AMOUNTS REDUCED BY 7% PER ANALYSIS OF SECTION 501 OF BIPA, UPDATED BY THE HOME HEALTH MARKET BASKET MINUS 1.1% FOR FY 2003 BEFORE CASE-MIX ADJUSTMENT, WAGE INDEX ADJUSTMENT BASED ON THE SITE OF SERVICE FOR THE BENEFICIARY OR APPLICABLE PAYMENT ADJUSTMENT

Total standardized prospective payment amount per 60-day episode for FY 2002	7% Reduction Due to Section 501 of BIPA	Multiply by 1 plus the Home Health Market Basket minus 1.1%	Final FY 2003 Updated National 60-day Episode Rate
$2,274.17	× .93	× 1.021	$2,159.39

• *National Per-visit Amounts Used to Pay LUPAs and Compute Imputed Costs used in Outlier Calculations.*

As discussed previously in this notice with comment period, the policies governing the LUPAs and outlier calculations set forth in the July 3, 2000 HH PPS final rule will continue during FY 2003. In calculating the annual update for the FY 2003 national per-visit amounts we use to pay LUPAs and to compute the imputed costs in outlier calculations, we again looked at the FY 2002 rates as a starting point. We used the same approach to implement section 501 of BIPA. The statute requires us to look at the 15 percent reduction to the IPS limits in FY 2003, 2 years after HH PPS has been implemented and the IPS has ended. As stated previously, we believe the HHAs would have altered their behavior to avoid reaching the IPS limits. We have determined that behavioral response would translate the required 15 percent reduction in cost limits into a 7 percent reduction in overall payments in FY 2003. In response to section 501 of BIPA, we reduced the national per-visit amounts by home health discipline by 7 percent. Those amounts are then increased by the FY 2003 home health market basket increase minus 1.1 percentage points to yield the updated per-visit amounts for each home health discipline for FY 2003. (See table below.)

NATIONAL PER-VISIT AMOUNTS FOR LUPAS AND OUTLIER CALCULATIONS REDUCED BY 7% PER ANALYSIS OF SECTION 501 OF BIPA, UPDATED BY THE HOME HEALTH MARKET BASKET MINUS 1.1% FOR FY 2003 BEFORE WAGE INDEX ADJUSTMENT BASED ON THE SITE OF SERVICE FOR THE BENEFICIARY OR APPLICABLE PAYMENT ADJUSTMENT UPDATED BY THE HOME HEALTH MARKET BASKET MINUS 1.1% FOR FY 2003

Home Health Discipline type	Final per-visit amounts per 60-day episode for FY 2002 for LUPAs	7% Reduction Due to section 501 of BIPA	Multiply by 1 plus Home Health Market Basket minus 1.1%	Final per-visit payment amount per discipline for FY 2003 for LUPAs
Home Health Aide	$44.95	× .93	× 1.021	$42.68
Medical Social Services	$159.14	× .93	× 1.021	$151.11
Occupational Therapy	$109.28	× .93	× 1.021	$103.77
Physical Therapy	$108.55	× .93	× 1.021	$103.07
Skilled Nursing	$99.28	× .93	× 1.021	$94.27
Speech-Language Pathology	$117.95	× .93	× 1.021	$112.00

C. Rural Add-On as Required by the BIPA

Section 508 of the BIPA requires, for home health services furnished in a rural area (as defined in section 1886(d)(2)(D) of the Act) on or after April 1, 2001 and before April 1, 2003, that the Secretary increase by 10 percent the payment amount otherwise made under section 1895 of the Act for services. The statute waives budget neutrality related to this provision as it specifically states that the Secretary shall not reduce the standard prospective payment amount (or amounts) under section 1895 of the Act applicable to home health services furnished during a period to offset the increase in payments resulting in the application of this section of the statute.

Section 508 provides for payment for the national standardized episode amounts and LUPA national per-visit amounts for the first half of FY 2003 by an additional 10 percent for home health services furnished in rural areas where the site of service for the beneficiary is a non-MSA area. By statute, the 10 percent rural add-on applies to home health services furnished in a rural area (as defined in section 1886(d)(2)(D) of the Act) on or after April 1, 2001 and before April 1, 2003. Therefore, the 10 percent rural add-on ends mid-FY 2003 for episodes ending on or after April 1, 2003. The applicable case-mix and wage index adjustment is subsequently applied for the provision of home health services where the site of service is the non-Metropolitan Statistical Area (MSA) of the beneficiary. Similarly, the applicable wage index adjustment is subsequently applied to the LUPA per-visit amounts adjusted for the provision of home health services where the site of service for the beneficiary is a non-MSA area. We implemented this provision for FY 2001 on April 1, 2001 through the Program Memorandum, ''Restoration of Full Home Health Market Basket Update for Home Health Services for Fiscal Year 2001 and Temporary 10 Percent Payment Increase for Home Health Services Furnished in a Rural Area for 24 Months Under the

Home Health Prospective Payment System (HH PPS)'' (Transmittal A–01–06 issued January 16, 2001) and for FY 2002 through the FY 2002 annual HH PPS update notice published on June 29, 2001 in the **Federal Register** (66 FR 34687). (See FY 2003 add-on noted in tables below.)

FY 2003 RURAL ADD-ON TO 60-DAY EPISODE PAYMENT AMOUNTS ENDING BEFORE APRIL 1, 2003 FOR BENEFICIARIES WHO RESIDE IN A NON-MSA AREA BEFORE CASE-MIX ADJUSTMENT, WAGE INDEX ADJUSTMENT BASED ON THE SITE OF SERVICE OF THE BENEFICIARY, OR APPLICABLE PAYMENT ADJUSTMENT

Payment amount per 60-day episode for FY 2003	10% add-on	FY 2003 Final payment amount per 60-day episode ending before April 1, 2003 for a beneficiary who 60-day resides in a rural non-MSA area
$2,159.39	× 1.10	$2,375.33

FY 2003 RURAL ADD-ON TO LUPA PER-VISIT AMOUNTS FOR EPISODES ENDING BEFOREAPRIL 1, 2003 BEFORE WAGE ADJUSTMENT BASED ON THE SITE OF SERVICE OF THE BENEFICIARY WHO RESIDES IN A NON-MSA AREA OR PAYMENT APPLICABLE ADJUSTMENT

Home Health Discipline type	Final per-visit payment amount per 60-day episodes for FY 2003 for LUPAs	10% add-on	FY 2003 Final per-visit payment amount per 60-day episodes ending Before April 1, 2003 for LUPAs for a beneficiary who resides in a non-MSA area
Home Health Aide	$ 42.68	× 1.10	$ 46.95
Medical Social Services	$151.11	× 1.10	$166.22
Occupational Therapy	$103.77	× 1.10	$114.15
Physical Therapy	$103.07	× 1.10	$113.38
Skilled Nursing	$ 94.27	× 1.10	$103.70
Speech-Language pathology	$112.00	× 1.10	$123.20

D. Wage Index

Sections 1895(b)(4)(A)(ii) and (b)(4)(C) of the Act require the Secretary to establish area wage adjustment factors that reflect the relative level of wages and wage-related costs applicable to the furnishing of home health services and to provide appropriate adjustments to the episode payment amounts under HH PPS to account for area wage differences. We apply the appropriate wage index value to the labor portion of the HH PPS rates based on the geographic area in which the beneficiary received home health services. We determine each HHA's labor market area based on definitions of MSAs issued by the Office of Management and Budget (OMB).

As discussed previously and set forth in the July 3, 2000 final rule, the statute provides that the wage adjustment factors may be the factors used by the Secretary for purposes of section 1886(d)(3)(E) of the Act for hospital wage adjustment factors. Again, as discussed in the July 3, 2000 final rule, we used the most recent pre-floor and pre-reclassified hospital wage index available at the time of publication of this notice to adjust the labor portion of the HH PPS rates based on the geographic area in which the beneficiary receives the home health services. We believe the use of the most recent available pre-floor and pre-reclassified hospital wage index data results in the appropriate adjustment to the labor portion of the costs as required by statute. (See addenda A and B of this notice with comment period, respectively, for the rural and urban hospital wage indexes.)

E. Clarification of Policy Governing Current Accelerated Payment Policy

Since the implementation of the HH PPS in 2000, we have received questions concerning the regulations governing accelerated payments under HH PPS. We wish to clarify the provisions for accelerated payments for HHAs set forth in § 484.245(a). This general rule was not meant to be restrictive, but to complement the regulations governing intermediary accelerated payments to providers in § 413.64(g). The regulations at § 413.64(g) governing the criteria for accelerated payments to providers have not changed under HH PPS. Accelerated payments are permitted under HH PPS for HHAs that meet the longstanding qualifying criteria. When a provider requests an accelerated payment, it may be made to the provider, as set forth in § 413.64(g). This provision includes an HHA that is receiving payment under the HH PPS under several conditions. For example, an HHA continues to be eligible to receive accelerated payment under § 413.64(g) if it is experiencing financial difficulties because there is a delay by the intermediary in making payments or in exceptional situations, in which the HHA has experienced a temporary delay in preparing and submitting bills to the intermediary beyond its normal billing cycle.

IV. Waiver of Proposed Rulemaking

We ordinarily publish a proposed notice in the **Federal Register** to provide

a period for public comment before the provisions of a notice such as this take effect. We can waive this procedure, however, if we find good cause that a notice-and-comment procedure is impracticable, unnecessary, or contrary to the public interest and we incorporate a statement of finding and its reasons in the notice issued.

We believe it is unnecessary to undertake a proposed notice with comment period as the statute requires annual updates to the HH PPS rates, the methodologies used to update the rate have been previously subject to public comment, and this notice reflects the application of previously established methodologies. Further, the rural add-on and adjustments to FY 2001 HH PPS rates that were required by the BIPA before this annual update for the FY 2003 PPS rates are dictated by statute and do not require an exercise of discretion. In addition, the clarification to the accelerated payment policy reflects no substantive change in policy and practice. Therefore, for good cause, we waive prior notice and comment procedures. As indicated previously, we are, however, providing a 60-day comment period for public comment.

V. Collection of Information Requirements

This document does not impose information collection and recordkeeping requirements. Consequently, it need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*).

VI. Response to Comments

Because of the large number of items of correspondence we normally receive on **Federal Register** documents published for comment, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and, if we proceed with a subsequent document, we will respond to the major comments in the preamble to that document.

VII. Regulatory Impact Analysis

A. Overall Impact

We have examined the impacts of this notice as required by Executive Order 12866 (September 1993, Regulatory Planning and Review) and the Regulatory Flexibility Act (RFA) (September 19, 1980 Pub. L. 96–354). Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year). The update set forth in this notice applies to Medicare payments under HH PPS in FY 2003. Accordingly, the analysis that follows describes the impact in FY 2003 only. We estimate that there will be an additional $320 million in FY 2003 expenditures attributable to the FY 2003 market basket increase of 2.1 percent. The statute requires the FY 2003 home health market basket increase of 3.2 percent to be reduced by 1.1 percentage points. Section 501 of BIPA requires the application of the 15 percent reduction on payment limits under the IPS, which is no longer in effect, for home health services updated to FY 2003. This statutory provision requires the estimation of what Medicare spending would have been if the IPS limits were reduced by 15 percent and updated to FY 2003. To achieve this level of home health spending, we will reduce the HH PPS rates by 7 percent. The impact on providers due to the implementation of the 7 percent reduction is to reduce Medicare home health spending by $821 million in FY 2003, $1,132 million in FY 2004, and $1,212 million in FY 2005. As stated above, the expenditures outlined in this notice exceed the $100 million yearly threshold for a major rule as defined in title 5, USC, section 804(2), and for a significant regulatory action as defined in E.O. 12866.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have 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 MSA and has fewer than 100 beds. We have determined that this notice with comment period will not have a significant economic impact on the operations of a substantial number of small rural hospitals.

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 $10 million or less annually. For purposes of the RFA, we consider most HHAs to be small entities. Individuals and States are not included in the definition of a small entity. This notice with comment period reflects the statutory update to the HH PPS rates published in the July 3, 2000 final rule as amended by the BIPA, but will have a significant positive effect upon small entities.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule that may result in expenditure in any 1 year by State, local, or tribal governments, in the aggregate, or by the private sector, of $110 million. We believe this notice with comment period will not mandate expenditures in that amount.

Executive Order 13132 establishes certain requirements that an agency must meet when it publishes a notice with comment period that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. We have reviewed this notice under the threshold criteria of Executive Order 13132, Federalism. We have determined that this notice will not have substantial direct effects on the rights, roles, and responsibilities of States.

B. Anticipated Effects

In accordance with the requirements of section 1895(b)(3) of the Act, we publish an update for each subsequent fiscal year that will provide an update to the payment rates. Section 1895(b)(3) of the Act requires us, for FY 2003, to increase the prospective payment amounts by the home health market basket increase minus 1.1 percentage points. The home health market basket increase for FY 2003 is 3.2 percent. Taking into account the provisions of section 1895(b)(3) of the Act, the FY 2003 home health market basket increase of 3.2 percent is reduced by 1.1 percentage points yielding a 2.1 percent increase for FY 2003. For the sake of clarity, we have also included the amounts as increased by the rural add-on provision under section 508 of the BIPA.

Before we determine the impact of the update of the FY 2002 national 60-day episode rate by the applicable home health market basket increase, we need to review prior legislation affecting home health payment systems. Section 4602 of the BBA implemented IPS for FY 1998 through FY 1999, which was composed of both per-visit limits and a per-beneficiary limit. The per-visit limits were similar to the per-visit limits

previously in place but reduced to 105 percent of the median (previous limits were set at 112 percent of the mean) and applied in the aggregate (that is, across disciplines, while the limits were specified for each of six disciplines). The per-beneficiary limit was a blend of an agency-specific rate and a national rate for agencies having a 1994 cost report and a national rate for those agencies not in existence in FY 1994. An agency was paid the lower of the following:

- Its actual costs.
- The costs from applying each of the per-discipline limits to the number of visits of that discipline, in the aggregate.
- The costs from applying the agency-specific limit to the number of beneficiaries served by that agency.

Section 4603 of BBA required that a PPS be implemented beginning with FY 2000. The implementation of PPS was, however, postponed until FY 2001 by section 5101(c) of OCESAA. BBA required that initial budget neutrality under HH PPS for FY 2000 be calculated for what expenditures would have been in FY 2000 if the IPS had continued to be in effect, but with both the per-visit and per-beneficiary limits in effect on September 30, 1999 (the last day of FY 1999) reduced by 15 percent. That is, we had to estimate what Medicare expenditures would have been if the IPS had continued for another year, but with the per-visit and per-beneficiary limits reduced by 15 percent. This further reduction of the per-visit and per-beneficiary limits was to ensure that home health spending was below the levels of the IPS.

BIPA did not delay the starting date for HH PPS. However, it did delay application of the 15-percent reduction in the IPS cost limits. The statute requires that HH PPS rates, beginning with FY 2003, be equal to the amounts that would have been effective for the IPS for FY 2001 with a 15-percent reduction in per-visit and per-beneficiary cost limits in effect on September 30, 2000, the last day of the IPS. The updates for FY 2003, as otherwise applied, would be added to the HH PPS reduced rates.

The key to the calculation is the estimation of what Medicare home health expenditures would have been in FY 2001. The determination of those expenditures requires, by statute, an estimation of those expenditures with the per-visit and per-beneficiary limits reduced by 15 percent. The estimate entails three key elements.

First, it requires an estimate of the distribution of agencies' costs relative to per-visit and per-beneficiary aggregate limits. For example, if all agencies' costs were at or above the per-visit or per-beneficiary limits, lowering the limits by 15 percent would have saved 15 percent. Similarly, if some agencies' costs were between 85 percent and 100 percent of either cost limit, lowering the cost limits by 15 percent would achieve less than 15 percent savings. Likewise, if some agencies' costs were below 85 percent of both cost limits, lowering the limits by 15 percent would not achieve savings (since agencies would be paid their actual costs).

Second, an estimation of home health expenditures for FY 2001 requires an estimate of the annual increase in the cost limits under IPS if the IPS cost limits were continued. Since IPS did not apply for FY 2001, the annual increase in cost limits that would have applied must be estimated. We also need to estimate how costs have increased relative to the cost limits. For example, the cost limits were increased by the market basket but agency costs would have most likely increased by some higher percentage.

Finally, under the statutory parameters, the estimate requires an assessment of the behavioral response of HHAs to a lowering of the per-visit and per-beneficiary limits that we estimate for FY 2001 home health expenditures. An assessment of behavioral response is particularly important given the patterns of Medicare home health spending and utilization that have fluctuated dramatically over the last 10 years. Dramatic increases in home health spending reflect very large increases in the number of visits per person served and increases in the number of persons receiving home health services. This is the behavioral response expected under a cost-based reimbursement system. Furthermore, HH PPS provides an incentive for agencies to provide fewer visits than before since they are paid a flat dollar amount to cover all services within a 60-day time period. Preliminary FY 2001 data show that the number of home health visits in the first year of HH PPS has decreased by a significant percentage compared to FY 2000, the last year of IPS. Meanwhile, reimbursement per visit is projected to increase substantially. This is the type of behavioral response that is consistent with the incentives of the new payment system.

Taking into account all these considerations and using the latest available reliable data, we have determined that at the time the BBA was passed, the 15-percent reduction in the limits would result in a 7-percent reduction in aggregate home health spending. We continue to believe that this is the best estimate of the level to which spending would have been reduced under the conditions prescribed by the BBA, namely extension of the IPS through FY 2001 (the first year of HH PPS) but with a 15-percent reduction in each of the IPS cost limits. Therefore, to achieve this level of home health spending, we will reduce the HH PPS payments by 7 percent.

At the time the BBA's enactment, the most recent settled cost report data for HHAs showed that most agencies' costs were at about the level of the existing cost limits. If the limits were lowered by 15 percent then, absent changes in the level of services provided, the resulting reduction in the HH PPS rates would be 15 percent. For example, if home health spending costs were $10 billion and all agencies were at the level of the limits, this level would also be $10 billion. If the level of the cost limits were lowered to $10 billion multiplied by (1 minus .15) it would be equal to $8.5 billion. Then savings to the Medicare program would be cost-limits divided by costs, for example, 1.5 billion divided by 10 billion or 15 percent.

CMS actuaries believed, based on past experience, that agencies would alter the nature and quantity of the services provided to achieve costs below the cost limits. Therefore, a full 15 percent reduction would not be required. The actuaries assumed that 50 percent of total HHA costs would be for agencies that reached the per beneficiary limits and 45 percent of total HHA costs would be for agencies that reached the per-visit limit. The actuaries further assumed that the remaining 5 percent of total HHA costs were under both limits before the 15 percent reduction. After the reduction, about 5 percent of their costs would now be over the limits. The actuaries assumed that 65 percent of the savings from the per beneficiary limit reduction would be lost and 50 percent of the savings from the per-visit limit reduction would be lost. For example, (.65 multiplied by .5) added to (.5 multiplied by .45) or 55 percent of the 15 percent reduction would be lost. This results in a net savings of (1–.55) multiplied by .15) added to (.05 multiplied by.05), or 7 percent. Thus, the actuaries estimate that HHAs faced with a potential 15 percent reduction would alter HHA behavior and would likely sustain a real reduction of only 7 percent. Because the real conditions under which behavior would change cannot be replicated, the actuaries continue to believe this model is the most appropriate expression of the statute's requirement for an estimate.

Both the applicable home health market basket increase of 2.1 percent for

FY 2003 and the 7 percent reduction in aggregate home health PPS payments due to the required 15 percent reduction in the estimation of the IPS limits apply to all Medicare participating HHAs. We do not believe there is a differential impact due to the aggregate nature of the update.

We implemented the rural add-on amounts for FY 2002, effective on April 1, 2001 through the Program Memorandum, ''Restoration of Full Home Health Market Basket Update for Home Health Services for Fiscal Year 2001 and Temporary 10 Percent Payment Increase for Home Health Services Furnished in a Rural Area for 24 Months Under the Home Health Prospective Payment System (HH PPS)'' (Transmittal A–01–06, issued January 16, 2001) and the FY 2002 HH PPS Update Notice (66 FR 34687). Section 508 of the BIPA provides a 10 percent rural add-on for home health services furnished to beneficiaries whose site of service is a rural area (non-MSA) for 24 months beginning with episodes ending on or after April 1, 2001 and before April 1, 2003. The 10 percent rural add on applies to episodes ending before April 1, 2003 and, therefore, will end mid FY 2003, as required by the statute.

1. Effects on the Medicare Program

This notice with comment period merely provides a percentage update to all Medicare HHAs. Therefore, we have not furnished any impact tables. We increase the payment to each Medicare HHA equally by the home health market basket update for FY 2003, as required by statute. There is no differential impact among provider types. The impact is in the aggregate. We estimate that there will be an additional $320 million in FY 2003 expenditures attributable to the applicable FY 2003 market basket increase of 2.1 percent. As stated above, expenditures outlined in this notice exceed the $100 million yearly threshold for a major rule, as defined in Title 5, U.S.C., section 804(2) and for a significant regulatory action, as defined in E.O. 12866.

As discussed previously, section 501 of BIPA impacts the estimated Medicare home health expenditures in FY 2003. Section 1864(b)(3)(A)(i)(III) of the Act, as redesignated by section 501 of the BIPA, requires for FY 2003 the estimation of what would have been paid under the IPS with the IPS cost limits reduced by 15 percent, if the IPS had been updated to FY 2003. At that time of the BBA, lowering the limits by 15 percent would have resulted in a reduction of 15 percent from Medicare home health spending, without any behavioral offset. However, as explained previously, we anticipate that due to the behavioral responses, the level by which actual payments would be reduced by lowering the IPS cost limits would not be the same as the percent by which the cost limits themselves would be lowered. The full impact of Medicare savings attributable to the 15 percent reduction in the IPS limits is lower due to the behavioral responses of the industry. The total savings reflecting the behavioral responses is divided by the estimates for spending, which yields the percent at which aggregate home health spending is lowered. That is, implementation of the 15 percent reduction in IPS cost limits would lead to a 7 percent reduction in aggregate home health spending and, therefore, equivalently a 7 percent reduction in home health payments. The statute requires us to look at the 15 percent reduction to the IPS limits updated to FY 2003. We believe the HHAs would have altered their behavior to avoid the cost limits and maintain that our assumptions surrounding the 7 percent reduction in overall payments is correct. Based on the latest available data, our best estimate is that a 15 percent reduction in cost limits would result in a 7 percent reduction in aggregate home health spending and, therefore yield a 7 percent increase in home health payments. Both the home health market basket increase of 2.1 percent for FY 2003 and the 7 percent reduction in aggregate home health PPS payments due to the application of the required 15 percent reduction in estimated IPS cost limits apply to all Medicare participating HHAs. We do not believe there is a differential impact because of the aggregate nature of the update.

As discussed above, we implemented a rural add-on of a 10-percent payment increase to the episode and per-visit payment amounts under the HH PPS for Medicare home health services furnished in a rural area for a 24-month period. The 10-percent rural add-on increases estimated Medicare home health expenditures by $220 million in FY 2003.

(Source: President's FY 2003 Budget)

We provide impact tables below that display projected Medicare home health spending, which includes the 15 percent reduction in the IPS cost limits, as required by statute, that translate into a 7 percent reduction in HH PPS rates in FY 2003. Under the President's FY 2003 Budget, which assumes no further delays in the reduction, Medicare's total home health spending is projected to increase 12.2 percent in FY 2003, 8.3 percent in FY 2004, and 7.4 percent in FY 2005.

The President's Budget for FY 2003 projects a 12.2 percent increase in home health spending in FY 2003. Approximately 6.8 percent of this increase is because payments for services rendered in FY 2002 will not be actually paid until FY 2003, hence a ''cash lag'' occurs. Per episode payments incurred in FY 2002 but not paid until FY 2003 will be at higher levels than payments for the same services both provided and paid in FY 2003 because per-episode rates will be reduced in FY 2003 to reflect the payment reduction required by BIPA. The remaining 5.4 percent is accounted for by additional assumptions concerning projected increases in utilization and case mix, a 2.1 percent inflation increase, and the 10 percent rural add-on required by BIPA. These factors interact with the rate reduction required by BIPA to produce the 5.4 percent increase in overall spending.

INCLUDES 7% REDUCTION DUE TO THE ''15% CUT IN IPS LIMITS'' EFFECTIVE 10/1/2002 AS REQUIRED BY SECTION 501 OF BIPA

FY	2003	2004	2005
In millions	$14,851	$16,080	$17,268
% increase	12.2	8.3	7.4

FY 2003 update to Home Health PPS rates required by the Act	Additional FY 2003 Medicare Home Health estimated expenditures due to annual update required by statute
Section 1895(b)(3)(B) of the Act requires HH PPS rates increased by home health market basket minus 1.1 percentage points in FY 2003 (2.4% increase).	$320 million.

Provision of Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA)	Additional FY 2003 Medicare Home Health estimated expenditures due to the BIPA provision
Section 508—10-percent rural add-on for Medicare home health services furnished in a rural area.	$220 million.

(Source: President's FY 2003 Budget)

2. Effects on Providers

This notice implements statutorily required adjustments to Medicare HH PPS rates for providers of Medicare home health services. We do not anticipate specific effects on other providers. This notice with comment period reflects the statutorily required annual update to the Medicare HH PPS rates published in the July 3, 2000 final rule and applies to the Medicare HHAs. We do not believe there is a differential impact because of the consistent and aggregate nature of the update.

C. Alternatives Considered

As discussed in section II, this notice with comment period reflects an annual update to the HH PPS rates as required by statute. Due to the lack of discretion provided in the statutory requirements governing this notice with comment period, we believe the statute provides no latitude for alternatives other than the approach set forth in this notice reflecting the FY 2003 annual update to the HH PPS rates. Also, as discussed in section II, for clarification this notice addresses the 10 percent rural add-on required under section 508 of the BIPA for home health services furnished to beneficiaries who reside in a rural non-MSA area. Other than the positive effect of the market basket increase, this notice with comment period will not have a significant economic impact nor will it impose an additional burden on small entities. When a regulation or notice imposes additional burden on small entities, we are required under the RFA to examine alternatives for reducing burden. Since this notice with comment period will not impose an additional burden, we have not examined alternatives.

D. Conclusion

We have examined the economic impact of this notice with comment period on small entities and have determined that the economic impact is positive, significant, and that all HHAs will be affected. To the extent that small rural hospitals are affiliated with HHAs, the impact on these facilities will also be positive. Finally, we have determined that the economic effects described above are largely the result of BIPA provisions that this notice addresses. We continue to analyze the appropriateness and accuracy of payments for differing case mixes.

In accordance with the provisions of Executive Order 12866, this notice with comment period was reviewed by the Office of Management and Budget.

ADDENDUM A.—FY 2002 WAGE INDEX FOR RURAL AREAS—PRE-FLOOR AND PRE-RECLASSIFIED

MSA Name	Wage Index
ALABAMA	0.7339
ALASKA	1.1862
ARIZONA	0.8681
ARKANSAS	0.7489
CALIFORNIA	0.9659
COLORADO	0.8811
CONNECTICUT	1.2077
DELAWARE	0.9589
FLORIDA	0.8794
GEORGIA	0.8295
GUAM	0.9611
HAWAII	1.1112
IDAHO	0.8718
ILLINOIS	0.8053

ADDENDUM A.—FY 2002 WAGE INDEX FOR RURAL AREAS—PRE-FLOOR AND PRE-RECLASSIFIED—Continued

MSA Name	Wage Index
INDIANA	0.8721
IOWA	0.8147
KANSAS	0.7812
KENTUCKY	0.7963
LOUISIANA	0.7596
MAINE	0.8721
MARYLAND	0.8859
MASSACHUSETTS	1.1454
MICHIGAN	0.9000
MINNESOTA	0.9035
MISSISSIPPI	0.7528
MISSOURI	0.7891
MONTANA	0.8655
NEBRASKA	0.8142
NEVADA	0.9727
NEW HAMPSHIRE	0.9779
NEW JERSEY [1]	.....
NEW MEXICO	0.8676
NEW YORK	0.8547
NORTH CAROLINA	0.8535
NORTH DAKOTA	0.7879
OHIO	0.8668
OKLAHOMA	0.7566
OREGON	1.0027
PENNSYLVANIA	0.8607
PUERTO RICO	0.4800
RHODE ISLAND [1]	.....
SOUTH CAROLINA	0.8512
SOUTH DAKOTA	0.7861
TENNESSEE	0.7928
TEXAS	0.7712
UTAH	0.9051
VERMONT	0.9466
VIRGINIA	0.8241
VIRGIN ISLANDS	0.6747
WASHINGTON	1.0209
WEST VIRGINIA	0.8067
WISCONSIN	0.9066
WYOMING	0.8747

[1] All counties within the State are classified as Urban.

ADDENDUM B.—FY 2002 WAGE INDEX FOR URBAN AREAS—PRE-FLOOR AND PRE-RECLASSIFIED

MSA	Urban area (Constituent Counties)	Wage index
0040	ABILENE, TX	0.7965
0060	AGUADILLA, PR	0.4683
0080	AKRON, OH	0.9876
0120	ALBANY, GA	1.0640
0160	ALBANY-SCHENECTADY-TROY, NY	0.8500
0200	ALBUQUERQUE, NM	0.9759
0220	ALEXANDRIA, LA	0.8029
0240	ALLENTOWN-BETHLEHEM-EASTON, PA	1.0077
0280	ALTOONA, PA	0.9126
0320	AMARILLO, TX	0.8711
0380	ANCHORAGE,AK	1.2570
0440	ANN ARBOR, MI	1.1098
0450	ANNISTON, AL	0.8276
0460	APPLETON-OSHKOSH-NEENAH, WI	0.9241

ADDENDUM B.—FY 2002 WAGE INDEX FOR URBAN AREAS—PRE-FLOOR AND PRE-RECLASSIFIED—Continued

MSA	Urban area (Constituent Counties)	Wage index
0470	ARECIBO, PR	0.4630
0480	ASHEVILLE, NC	0.9200
0500	ATHENS, GA	0.9842
0520	ATLANTA, GA	1.0058
0560	ATLANTIC-CAPE MAY, NJ	1.1293
0580	AUBURN-OPELIKA, AL	0.8230
0600	AUGUSTA-AIKEN, GA–SC	0.9970
0640	AUSTIN-SAN MARCOS, TX	0.9630
0680	BAKERSFIELD, CA	0.9519
0720	BALTIMORE, MD	0.9856
0733	BANGOR, ME	0.9593
0743	BARNSTABLE-YARMOUTH, MA	1.3626
0760	BATON ROUGE, LA	0.8149
0840	BEAUMONT-PORT ARTHUR, TX	0.8442
0860	BELLINGHAM, WA	1.1826
0870	BENTON HARBOR, MI	0.8887
0875	BERGEN-PASSAIC, NJ	1.1689
0880	BILLINGS, MT	0.9352
0920	BILOXI-GULFPORT-PASCAGOULA, MS	0.8440
0960	BINGHAMTON, NY	0.8446
1000	BIRMINGHAM, AL	0.8808
1010	BISMARCK, ND	0.7984
1020	BLOOMINGTON, IN	0.8842
1040	BLOOMINGTON-NORMAL, IL	0.9038
1080	BOISE CITY, ID	0.9050
1123	BOSTON-WORCESTER-LAWRENCE-LOWELL-BROCKTON, M	1.1383
1125	BOULDER-LONGMONT, CO	0.9799
1145	BRAZORIA, TX	0.8209
1150	BREMERTON, WA	1.0758
1240	BROWNSVILLE-HARLINGEN-SAN BENITO, TX	0.9012
1260	BRYAN-COLLEGE STATION, TX	0.9328
1280	BUFFALO-NIAGARA FALLS, NY	0.9459
1303	BURLINGTON, VT	0.9883
1310	CAGUAS, PR	0.4699
1320	CANTON-MASSILLON, OH	0.8956
1350	CASPER, WY	0.9496
1360	CEDAR RAPIDS, IA	0.8699
1400	CHAMPAIGN-URBANA, IL	0.9306
1440	CHARLESTON-NORTH CHARLESTON, SC	0.9206
1480	CHARLESTON, WV	0.9264
1520	CHARLOTTE-GASTONIA-ROCK HILL, NC–SC	0.9336
1540	CHARLOTTESVILLE, VA	1.0566
1560	CHATTANOOGA, TN–GA	0.9369
1580	CHEYENNE, WY	0.8288
1600	CHICAGO, IL	1.1046
1620	CHICO-PARADISE, CA	0.9856
1640	CINCINNATI, OH–KY–IN	0.9473
1660	CLARKSVILLE-HOPKINSVILLE, TN–KY	0.8337
1680	CLEVELAND-LORAIN-ELYRIA, OH	0.9457
1720	COLORADO SPRINGS, CO	0.9744
1740	COLUMBIA, MO	0.8686
1760	COLUMBIA, SC	0.9492
1800	COLUMBUS, GA–AL	0.8440
1840	COLUMBUS, OH	0.9565
1880	CORPUS CHRISTI, TX	0.8341
1890	CORVALLIS, OR	1.1646
1900	CUMBERLAND, MD–WV	0.8306
1920	DALLAS, TX	0.9936
1950	DANVILLE, VA	0.8613
1960	DAVENPORT-ROCK ISLAND-MOLINE, IA–IL	0.8638
2000	DAYTON–SPRINGFIELD, OH	0.9225
2020	DAYTONA BEACH, FL	0.8972
2030	DECATUR, AL	0.8775
2040	DECATUR, IL	0.7987
2080	DENVER, CO	1.0328
2120	DES MOINES, IA	0.8779
2160	DETROIT, MI	1.0487
2180	DOTHAN, AL	0.7948
2190	DOVER, DE	1.0296
2200	DUBUQUE, IA	0.8519
2240	DULUTH-SUPERIOR, MN–WI	1.0284

ADDENDUM B.—FY 2002 WAGE INDEX FOR URBAN AREAS—PRE-FLOOR AND PRE-RECLASSIFIED—Continued

MSA	Urban area (Constituent Counties)	Wage index
2281	DUTCHESS COUNTY, NY	1.0532
2290	EAU CLAIRE, WI	0.8899
2320	EL PASO, TX	0.9215
2330	ELKHART-GOSHEN, IN	0.9638
2335	ELMIRA, NY	0.8415
2340	ENID, OK	0.8357
2360	ERIE, PA	0.8716
2400	EUGENE-SPRINGFIELD, OR	1.1471
2440	EVANSVILLE-HENDERSON, IN–KY	0.8514
2520	FARGO-MOORHEAD, ND–MN	0.9267
2560	FAYETTEVILLE, NC	0.9027
2580	FAYETTEVILLE-SPRINGDALE-ROGERS, AR	0.8445
2620	FLAGSTAFF, ARIZONA-UTAH	1.0556
2640	FLINT, MI	1.0913
2650	FLORENCE, AL	0.7845
2655	FLORENCE, SC	0.8722
2670	FORT COLLINS-LOVELAND, CO	1.0045
2680	FORT LAUDERDALE, FL	1.0293
2700	FORT MYERS-CAPE CORAL, FL	0.9374
2710	FORT PIERCE-PORT ST. LUCIE, FL	1.0214
2720	FORT SMITH, AR–OK	0.8053
2750	FORT WALTON BEACH, FL	0.9002
2760	FORT WAYNE, IN	0.9203
2800	FORT WORTH-ARLINGTON, TX	0.9394
2840	FRESNO, CA	0.9984
2880	GADSDEN, AL	0.8792
2900	GAINESVILLE, FL	0.9481
2920	GALVESTON-TEXAS CITY, TX	1.0313
2960	GARY, IN	0.9530
2975	GLENS FALLS, NY	0.8336
2980	GOLDSBORO, NC	0.8709
2985	GRAND FORKS, ND–MN	0.9069
2995	GRAND JUNCTION, CO	0.9569
3000	GRAND RAPIDS-MUSKEGON-HOLLAND, MI	1.0048
3040	GREAT FALLS, MT	0.8870
3060	GREELEY, CO	0.9495
3080	GREEN BAY, WI	0.9208
3120	GREENSBORO-WINSTON-SALEM-HIGH POINT, NC	0.9539
3150	GREENVILLE, NC	0.9289
3160	GREENVILLE-SPARTANBURG-ANDERSON, SC	0.9217
3180	HAGERSTOWN, MD	0.8365
3200	HAMILTON-MIDDLETOWN, OH	0.9287
3240	HARRISBURG-LEBANON-CARLISLE, PA	0.9425
3283	HARTFORD, CT	1.1533
3285	HATTIESBURG, MS	0.7476
3290	HICKORY-MORGANTON-LENOIR, NC	0.9367
3320	HONOLULU, HI	1.1539
3350	HOUMA, LA	0.7975
3360	HOUSTON, TX	0.9631
3400	HUNTINGTON-ASHLAND, WV–KY–OH	0.9616
3440	HUNTSVILLE, AL	0.8883
3480	INDIANAPOLIS, IN	0.9698
3500	IOWA CITY, IA	0.9859
3520	JACKSON, MI	0.9257
3560	JACKSON, MS	0.8491
3580	JACKSON, TN	0.9013
3600	JACKSONVILLE, FL	0.9223
3605	JACKSONVILLE, NC	0.7622
3610	JAMESTOWN, NY	0.8050
3620	JANESVILLE-BELOIT, WI	0.9739
3640	JERSEY CITY, NJ	1.1178
3660	JOHNSON CITY-KINGSPORT-BRISTOL, TN–VA	0.8617
3680	JOHNSTOWN, PA	0.8723
3700	JONESBORO, AR	0.8425
3710	JOPLIN, MO	0.8727
3720	KALAMAZOO–BATTLE CREEK, MI	1.0639
3740	KANKAKEE, IL	0.9889
3760	KANSAS CITY, MO–KS	0.9536
3800	KENOSHA, WI	0.9568
3810	KILLEEN–TEMPLE, TX	0.8471
3840	KNOXVILLE, TN	0.8890

ADDENDUM B.—FY 2002 WAGE INDEX FOR URBAN AREAS—PRE-FLOOR AND PRE-RECLASSIFIED—Continued

MSA	Urban area (Constituent Counties)	Wage index
3850	KOKOMO, IN	0.9126
3870	LA CROSSE, WI–MN	0.9250
3880	LAFAYETTE, LA	0.8544
3920	LAFAYETTE, IN	0.9121
3960	LAKE CHARLES, LA	0.7765
3980	LAKELAND–WINTER HAVEN, FL	0.9067
4000	LANCASTER, PA	0.9296
4040	LANSING–EAST LANSING, MI	0.9653
4080	LAREDO, TX	0.7849
4100	LAS CRUCES, NM	0.8621
4150	LAWRENCE, KS	0.7812
4120	LAS VEGAS, NV–AZ	1.1182
4200	LAWTON, OK	0.8682
4243	LEWISTON–AUBURN, ME	0.9287
4280	LEXINGTON, KY	0.8791
4320	LIMA, OH	0.9470
4360	LINCOLN, NE	1.0173
4400	LITTLE ROCK–NORTH LITTLE ROCK, AR	0.8955
4420	LONGVIEW–MARSHALL, TX	0.8571
4480	LOS ANGELES–LONG BEACH, CA	1.1948
4520	LOUISVILLE, KY–IN	0.9529
4600	LUBBOCK, TX	0.8449
4640	LYNCHBURG, VA	0.9103
4680	MACON, GA	0.8957
4720	MADISON, WI	1.0337
4800	MANSFIELD, OH	0.8708
4840	MAYAGUEZ, PR	0.4860
4880	MCALLEN–EDINBURG–MISSION, TX	0.8378
4890	MEDFORD–ASHLAND, OR	1.0314
4900	MELBOURNE–TITUSVILLE–PALM BAY, FL	0.9913
4920	MEMPHIS, TN–AR–MS	0.8978
4940	MERCED, CA	0.9947
5000	MIAMI, FL	0.9950
5015	MIDDLESEX–SOMERSET–HUNTERDON, N	1.1469
5080	MILWAUKEE–WAUKESHA, WI	0.9971
5120	MINNEAPOLIS–ST. PAUL, MN–WI	1.0930
5140	MISSOULA, MONTANA	0.9364
5160	MOBILE, AL	0.8082
5170	MODESTO, CA	1.0820
5190	MONMOUTH–OCEAN, NJ	1.0851
5200	MONROE, LA	0.8201
5240	MONTGOMERY, AL	0.7359
5280	MUNCIE, IN	0.9939
5330	MYRTLE BEACH, SC	0.8771
5345	NAPLES, FL	0.9699
5360	NASHVILLE, TN	0.9754
5380	NASSAU–SUFFOLK, NY	1.3643
5483	NEW HAVEN-BRIDGEPORT-STAMFORD-WATERBURY-DANB	1.2238
5523	NEW LONDON–NORWICH, CT	1.1526
5560	NEW ORLEANS, LA	0.9036
5600	NEW YORK–NEWARK, NY–NJ–PA	1.4427
5640	NEWARK, NJ	1.1622
5660	NEWBURGH, NY–PA	1.1113
5720	NORFOLK-VIRGINIA BEACH-NEWPORT NEWS, VA–NC	0.8579
5775	OAKLAND, CA	1.5319
5790	OCALA, FL	0.9556
5800	ODESSA-MIDLAND, TX	1.0104
5880	OKLAHOMA CITY, OK	0.8694
5910	OLYMPIA, WA	1.1350
5920	OMAHA, NE–IA	0.9712
5945	ORANGE COUNTY, CA	1.1123
5960	ORLANDO, FL	0.9642
5990	OWENSBORO, KY	0.8334
6015	PANAMA CITY, FL	0.9061
6020	PARKERSBURG-MARIETTA, WV–OH	0.8133
6080	PENSACOLA, FL	0.8361
6120	PEORIA-PEKIN, IL	0.8773
6160	PHILADELPHIA, PA–NJ	1.0947
6200	PHOENIX-MESA, AZ	0.9638
6240	PINE BLUFF, AR	0.7895
6280	PITTSBURGH, PA	0.9560

ADDENDUM B.—FY 2002 WAGE INDEX FOR URBAN AREAS—PRE-FLOOR AND PRE-RECLASSIFIED—Continued

MSA	Urban area (Constituent Counties)	Wage index
6323	PITTSFIELD, MA	1.0278
6340	POCATELLO, ID	0.9448
6360	PONCE, PR	0.5218
6403	PORTLAND, ME	0.9427
6440	PORTLAND-VANCOUVER,OR–WA	1.1111
6483	PROVIDENCE-WARWICK-PAWTUCKET, RI	1.0805
6520	PROVO-OREM, UT	0.9843
6560	PUEBLO, CO	0.8604
6580	PUNTA GORDA, FL	0.9015
6600	RACINE, WI	0.9333
6640	RALEIGH-DURHAM-CHAPEL HILL, NC	0.9818
6660	RAPID CITY, SD	0.8869
6680	READING, PA	0.9583
6690	REDDING, CA	1.1155
6720	RENO, NV	1.0421
6740	RICHLAND-KENNEWICK-PASCO, WA	1.0960
6760	RICHMOND-PETERSBURG, VA	0.9678
6780	RIVERSIDE-SAN BERNADINO, CA	1.1112
6800	ROANOKE, VA	0.8371
6820	ROCHESTER, MN	1.1462
6840	ROCHESTER, NY	0.9347
6880	ROCKFORD, IL	0.9204
6895	ROCKY MOUNT, NC	0.9109
6920	SACRAMENTO, CA	1.1831
6960	SAGINAW-BAY CITY-MIDLAND, MI	0.9590
6980	ST. CLOUD, MN	0.9851
7000	ST JOSEPH, MO	0.7891
7040	ST. LOUIS, MO–IL	0.8931
7080	SALEM, OR	1.0011
7120	SALINAS, CA	1.4684
7160	SALT LAKE CITY-OGDEN, UT	0.9863
7200	SAN ANGELO, TX	0.8193
7240	SAN ANTONIO, TX	0.8584
7320	SAN DIEGO, CA	1.1265
7360	SAN FRANCISCO, CA	1.4140
7400	SAN JOSE, CA	1.4193
7440	SAN JUAN-BAYAMON, PR	0.4762
7460	SAN LUIS OBISPO-ATASCADERO-PASO ROBLES, CA	1.0990
7480	SANTA BARBARA-SANTA MARIA-LOMPOC, CA	1.0802
7485	SANTA CRUZ-WATSONVILLE, CA	1.3970
7490	SANTA FE, NM	1.0194
7500	SANTA ROSA, CA	1.3034
7510	SARASOTA-BRADENTON, FL	1.0090
7520	SAVANNAH, GA	1.0018
7560	SCRANTON-WILKES-BARRE-HAZLETON, PA	0.8683
7600	SEATTLE-BELLEVUE-EVERETT, WA	1.1361
7610	SHARON, PA	0.7926
7620	SHEBOYGAN, WI	0.8427
7640	SHERMAN-DENISON, TX	0.9373
7680	SHREVEPORT-BOSSIER CITY, LA	0.9050
7720	SIOUX CITY, IA–NE	0.8767
7760	SIOUX FALLS, SD	0.9139
7800	SOUTH BEND, IN	0.9993
7840	SPOKANE, WA	1.0668
7880	SPRINGFIELD, IL	0.8676
7920	SPRINGFIELD, MO	0.8567
8003	SPRINGFIELD, MA	1.0881
8050	STATE COLLEGE, PA	0.9133
8080	STEUBENVILLE-WEIRTON, OH–WV	0.8637
8120	STOCKTON-LODI, CA	1.0815
8140	SUMTER, SC	0.7794
8160	SYRACUSE, NY	0.9621
8200	TACOMA, WA	1.1616
8240	TALLAHASSEE, FL	0.8527
8280	TAMPA-ST. PETERSBURG-CLEARWATER, FL	0.8925
8320	TERRE HAUTE, IN	0.8532
8360	TEXARKANA, TX-TEXARKANA, AR	0.8327
8400	TOLEDO, OH	0.9809
8440	TOPEKA, KS	0.8912
8480	TRENTON, NJ	1.0416
8520	TUCSON, AZ	0.8967

ADDENDUM B.—FY 2002 WAGE INDEX FOR URBAN AREAS—PRE-FLOOR AND PRE-RECLASSIFIED—Continued

MSA	Urban area (Constituent Counties)	Wage index
8560	TULSA, OK	0.8902
8600	TUSCALOOSA, AL	0.8171
8640	TYLER, TX	0.9641
8680	UTICA-ROME, NY	0.8329
8720	VALLEJO-FARIFIELD-NAPA, CA	1.3562
8735	VENTURA, CA	1.0994
8750	VICTORIA, TX	0.8328
8760	VINELAND-MILLVILLE-BRIDGETON, NJ	1.0441
8780	VISALIA-TULARE-PORTERVILLE, CA	0.9628
8800	WACO, TX	0.8129
8840	WASHINGTON, DC–MD–VA–WV	1.0962
8920	WATERLOO-CEDAR FALLS, IA	0.8041
8940	WAUSAU, WI	0.9696
8960	WEST PALM BEACH-BOCA RATON, FL	0.9777
9000	WHEELING, WV–OH	0.7985
9040	WICHITA, KS	0.9606
9080	WICHITA FALLS, TX	0.7867
9140	WILLIAMSPORT, PA	0.8628
9160	WILMINGTON-NEWARK, DE–MD	1.0877
9200	WILMINGTON, NC	0.9409
9260	YAKIMA, WA	1.0567
9270	YOLO, CA	0.9701
9280	YORK, PA	0.9441
9320	YOUNGSTOWN-WARREN, OH	0.9563
9340	YUBA CITY, CA	1.0359
9360	YUMA, AZ	0.8989

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: March 12, 2002.

Thomas A. Scully,

Administrator, Health Care Financing Administration.

Dated: May 10, 2002.

Tommy G. Thompson,

Secretary.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–4023–FN]

RIN 0938–ZA16

Medicare Program; Medicare+Choice Organizations—Approval of the Accreditation Association for Ambulatory Health Care, Inc. (AAAHC) for Medicare+Choice (M+C) Deeming Authority of M+C Organizations That Are Licensed as Health Maintenance Organizations (HMOs) or Preferred Provider Organizations (PPOs)

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Final notice.

SUMMARY: This final notice announces the approval of the Accreditation Association for Ambulatory Health Care, Inc. (AAAHC) for deeming authority of Medicare+Choice (M+C) organizations that are licensed as health maintenance organizations (HMOs) or preferred provider organizations (PPOs). We have found that the AAAHC's standards for managed care plans submitted to us and amended during the application process, meet or exceed those established by the Medicare program. Therefore, M+C organizations that are licensed as HMOs or PPOs and are accredited by AAAHC may receive, at their request, deemed status for the M+C requirements in the six areas—Quality Assurance, Information on Advance Directives, Antidiscrimination, Access to Services, Provider Participation Rules, and Confidentiality and Accuracy of Enrollee Records—that are specified in section 1852(e)(4)(B) of the Social Security Act (the Act).

Regulations set forth in § 422.157(b)(2) specify that the Secretary will publish a **Federal Register** notice that indicates whether an accreditation organization's request for approval has been granted and the effective date and term of the approval, which may not exceed 6 years.

FOR FURTHER INFORMATION CONTACT: Trisha Kurtz, (410) 786–4670.

I. Background

Under the Medicare program, eligible beneficiaries may receive covered services through a managed care organization that has a Medicare+Choice (M+C) contract with us. To enter into an M+C contract, the organization must be licensed by the State as a risk-bearing entity and must meet the requirements that are set forth in 42 CFR part 422. Those regulations implement Part C of Title XVIII of the Social Security Act (the Act), that specifies the services that a managed care organization must provide and the requirements that the organization must meet to be an M+C contractor. Other relevant sections of the Act are Parts A and B of Title XVIII and Part A of Title XI pertaining to the provision of services by Medicare certified providers and suppliers.

Following approval of the M+C contract, we engage in routine monitoring of the M+C organization to ensure continuing compliance. The monitoring process is comprehensive and uses a written protocol that specifies the Medicare requirements the M+C organization must meet.

A M+C organization may be exempt from our monitoring of the requirements that are in the areas listed in section 1852(e)(4)(B) of the Act if the organization is accredited by a CMS-approved accrediting organization. In essence, the Secretary ''deems'' that the Medicare requirements are met based on