ADDENDUM L.—OUT-MIGRATION WAGE ADJUSTMENT CY 2006 [1]—Continued

Provider no.	Redesignation indicator	Out-migration adjustment	Qualifying county name
520096	*	0.0200	Racine.
520102	*	0.0298	Walworth.
520116	*	0.0239	Jefferson.
520132	.....	0.0077	Sheboygan.
522005	.....	0.0200	Racine.
523026	.....	0.0200	Racine.
524020	.....	0.0118	Sauk.
524021	.....	0.0298	Walworth.

*Hospitals that have been reclassified under section 1886(d)(10) of the Act, reclassified under section 508 Pub. L. 108–173, or redesignated under section 1886(d)(8) of the Act.

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

Dated: December 20, 2005.

Ann C. Agnew,

Executive Secretary to the Department.

[FR Doc. 05–24447 Filed 12–22–05; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 422

[CMS–4069–F4]

RIN 0938–AN06

Medicare Program; Establishment of the Medicare Advantage Program

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

ACTION: Final rule; correcting amendment.

SUMMARY: This document corrects technical errors that appeared in the final rule published in the **Federal Register** on January 28, 2005 entitled ''Establishment of the Medicare Advantage Program.''

DATES: Except amendments to §§ 422.316 and 422.503, this final rule is effective March 22, 2005. Section 422.316(a), which was stayed from September 1, 2005, until January 1, 2006, by FR Doc. 05–17280 published on September 1, 2005 (70 FR 52023), is effective January 1, 2006. Section 422.503(b)(4)(ii) is effective December 23, 2005.

FOR FURTHER INFORMATION CONTACT: Christopher McClintick, (410) 786–4682.

SUPPLEMENTARY INFORMATION:

I. Background

In FR Doc. 05–1322 of January 28, 2005 (70 FR 4588), there were several errors that we identified and corrected in a correcting amendment published September 1, 2005 (FR Doc. 05–17285, 70 FR 52023). Based on further review of the January 28, 2005, final rule, we are making additional typographical and conforming changes. We identify these changes in the ''Summary of Errors'' section and correct these errors in the ''Correction of Errors'' section below. The provisions in this correcting amendment are effective as if they were included in the final rule published on January 28, 2005. Accordingly, with the exception of the revisions to § 422.316(a), which are stayed until January 1, 2006, and § 422.503(b)(4)(ii), which are effective December 23, 2005, the corrections are effective retroactive to March 22, 2005, the effective date of most of the provisions of the January 28, 2005 final rule.

II. Summary of Errors

The errors we are correcting in this correcting amendment pertain to the regulations text only. The changes follow the sequence of the CFR sections affected.

In § 422.2 of the final rule, in the definition of ''Provider network,'' we inadvertently did not include a reference to a ''network Private Fee-for-Service (PFFS) plan,'' a new option made possible by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA).

In § 422.101, in paragraph (b)(4), we inadvertently referenced paragraph (b)(3) when specifying an exception to the requirements concerning the review of uniform local coverage policies, instead of (b)(3)(ii), the paragraph upon which the exception is based.

In § 422.112, we are revising paragraph (c)(5), which specifies the requirements for designation as an essential hospital, to clarify that the requirement applies to hospitals that are already designated as an essential hospital.

In § 422.216, we are revising paragraphs (b)(1)(i) and (b)(1)(iii) to conform to the changes we made in § 422.114(c) as a result of the changes to section 1852(j) of the Social Security Act (the Act), which explicitly allows PFFS plans to charge differential cost sharing in certain instances.

Also, in § 422.216, which concerns provider credentialing requirements, in paragraph (i) we are correcting typographical errors that resulted in the reference to two non-existent regulations text sections.

In § 422.256, we are revising paragraph (b)(3) to remove a confusing and inadvertent reference to Medicare Savings Account (MSA) plans.

In § 422.316, we are revising paragraph (a) to more clearly indicate that, consistent with section 1833(a)(3)(B) of the Act, the supplemental payment CMS will make directly to the Federally Qualified Health Center (FQHC) is net of what the FQHC may charge as cost sharing under its contract with the Medicare Advantage (MA) organization, not the cost sharing amounts that the FQHC actually collects.

In § 422.503, we are revising paragraph (b)(4)(ii) to revert to a paragraph concerning the administrative and management arrangements necessary to qualify as an MA organization that was inadvertently replaced in the final rule. We are making one technical change to the provision, to refer to ''quality improvement'' instead of ''quality assurance,'' to conform to the change in terminology implemented as part of the MMA.

III. Waiver of Proposed Rulemaking

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** to provide a period for public comment before the provisions of a rule take effect in accordance with section 553(b) of the Administrative Procedure

Act (APA) (5 U.S.C. 553(b)). However, we can waive this notice and comment procedure if the Secretary finds, for good cause, that the notice and comment process is impracticable, unnecessary, or contrary to the public interest, and incorporates a statement of the finding and the reasons therefore in the notice.

Section 553(d) of the Administrative Procedure Act ordinarily requires a 30-day delay in effective date of final rules after the date of their publication in the **Federal Register**. This 30-day delay in effective date can be waived, however, if an agency finds for good cause that the delay is impracticable, unnecessary, or contrary to the public interest, and the agency incorporates a statement of the findings and its reasons in the rule issued. In addition, section 1871(e)(1)(B) of the Act provides that substantive changes may take effect before the end of the 30-day period that begins on the date that the Secretary has issued the substantive change only if the waiver of the 30-day period is necessary to comply with statutory requirements or the application of the 30-day delay is contrary to the public interest.

Most of the revisions contained in this rule concern conforming changes, correcting cross references, and typographical errors, and therefore, are not substantive. Because they are not substantive, we find that public comment on these revisions is not necessary. The revisions do not represent changes to our policy, and the public interest would, as a result, be best served by timely correction of these technical errors. A delay in the applicability of the non-substantive changes would be contrary to public interest in that such corrections are necessary for, especially, plans transitioning to the new Medicare Advantage program.

One correction that could be viewed as substantive is the change to § 422.503(b)(4)(ii). With respect to this provision, we are revising this paragraph to include language that we had inadvertently deleted pertaining to the administrative and management qualifications of an MA organization. In the case of this substantive correction, we find that public comment is unnecessary because the correction removes an unintended change that was never proposed, not commented on by the public, and not discussed in the preamble to the final rule, and reverts to the language that was in place prior to the effective date of the final rule (except for a technical change of ''quality assurance'' to ''quality improvement'' to reflect a terminology change implemented in the MMA). We believe that failure to correct this error would result in confusion for MA organizations, which is contrary to the public interest. We also find that the 30-day delay ordinarily called for under the APA and section 1871(e)(1)(B) of the Act is contrary to the public interest because the incorrect language that inadvertently replaced the affected section on administrative and management qualifications could, if left in place, result in confusion when the majority of changes to the MA program implemented as a result of the MMA begin on January 1, 2006.

Section 1871(e)(1)(A) of the Act, as amended by section 903(a) of Pub. L. 108–173, provides that a substantive change in regulations shall not be applied retroactively to items and services furnished before the effective date of the change, unless the Secretary finds that such retroactive application is necessary to comply with statutory requirements or failure to apply the change retroactively would be contrary to the public interest.

The provisions of this correcting amendment that apply retroactively make no substantive changes, but merely correct minor technical errors. Failure to make these changes retroactive to March 22, 2005, is contrary to the public interest because of the confusion that could result from the technical errors identified above. It is in the public interest to make the corrections retroactive in that it will help prevent confusion among plans that must now follow these requirements beginning January 1, 2006.

IV. Correction of Errors

Make the following corrections to the regulation text in the January 28, 2005 final rule (70 FR 4588):

List of Subjects in 42 CFR Part 422

Administrative practice and procedure, Health facilities, Health maintenance organizations (HMO), Medicare, Penalties, Privacy, Reporting and recordkeeping requirements

■ Accordingly, 42 CFR chapter IV is corrected by making the following correcting amendments to part 422:

PART 422—MEDICARE ADVANTAGE PROGRAM

■ 1. The authority citation for part 422 continues to read as follows:

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

■ 2. Amend § 422.2, by revising the definition of ''Provider network'' to read as follows:

§ 422.2 Definitions.

* * * * *

Provider network means the providers with which an MA organization contracts or makes arrangements to furnish covered health care services to Medicare enrollees under an MA coordinated care plan or network PFFS plan.

* * * * *

§ 422.101 [Corrected]

■ 3. Amend § 422.101 paragraph (b)(4), by removing the reference ''(b)(3)'' and adding in its place the reference ''(b)(3)(ii).''

■ 4. Amend § 422.112, by revising paragraph (c)(5) to read as follows:

§ 422.112 Access to services.

* * * * *

(c) * * *

(5) The hospital that is an essential hospital under this paragraph provides convincing evidence to CMS that the amounts normally payable under section 1886 of the Act (and which the MA regional plan has agreed to pay) will be less than the hospital's actual costs of providing care to the MA regional plan's enrollee.

* * * * *

■ 5. Amend § 422.216 by—
■ A. Revising paragraph (b)(1)(i).
■ B. Revising paragraph (b)(1)(iii).
■ C. Revising paragraph (i).

The revisions read as follows:

§ 422.216 Special rules for MA private fee-for-service plans.

* * * * *

(b) * * *

(1) * * *

(i) Contract providers and ''deemed'' contract providers may charge enrollees no more than the cost-sharing and, subject to the limit in paragraph (b)(1)(ii) of this section, balance billing amounts that are permitted under the plan, and these amounts must be the same for ''deemed'' contract providers as for those that have signed contracts in effect, unless access requirements with respect to a particular category of health care providers are met solely through § 422.114(a)(2)(ii) and the MA organization imposes higher beneficiary copayments as permitted under § 422.114(c).

* * * * *

(iii) The MA organization must specify the amount of cost-sharing and balance billing in its contracts with providers and these amounts must be the same for ''deemed'' contract providers as for those that have signed contracts in effect, unless access requirements with respect to a

particular category of health care providers are met solely through § 422.114(a)(2)(ii) and the MA organization imposes higher beneficiary copayments as permitted under § 422.114(c).

* * * * *

(i) *Provider credential requirements.* Contracts with providers must provide that, in order to be paid to provide services to plan enrollees, providers must meet the requirements specified in §§ 422.204(b)(1)(i) and (b)(3).

■ 6. Amend § 422.256, by revising paragraph (b)(3) introductory text to read as follows:

§ 422.256 Review, negotiation and approval of bid.

* * * * *

(b) * * *

(2) * * *

(3) *Limitation on enrollee cost sharing.* For coordinated care plans (including regional MA plans and specialized MA plans) and private fee-for-service plans:

* * * * *

■ 7. Amend § 422.316 by revising paragraph (a) to read as follows:

§ 422.316 Special rules for payouts to Federally qualified health centers.

* * * * *

(a) CMS will pay the amount determined under section 1833(a)(3)(B) of the Act directly to the FQHC at a minimum on a quarterly basis, less the amount the FQHC would receive for the MA enrollee from the MA organization (which includes the cost sharing amount the FQHC may charge an enrollee, as established in the contract between the FQHC and the MA organization); and

* * * * *

■ 8. Amend § 422.503 by revising paragraph (b)(4)(ii) to read as follows:

§ 422.503 General provisions.

* * * * *

(b) * * *

(4) * * *

(ii) Personnel and systems sufficient for the MA organization to organize, implement, control, and evaluate financial and marketing activities, the furnishing of services, the quality improvement program, and the administrative and management aspects of the organization.

* * * * *

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

Dated: December 20, 2005.

Ann C. Agnew,

Executive Secretary to the Department.

[FR Doc. 05–24446 Filed 12–22–05; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 423

[CMS–0011–CN]

RIN 0938–AN49

Medicare Program; E-Prescribing and the Prescription Drug Program; Correction

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

ACTION: Final rule; Correction.

SUMMARY: This document corrects technical errors that appeared in the final rule published in the **Federal Register** on November 7, 2005, entitled ''Medicare Program; E-Prescribing and the Prescription Drug Program.''

EFFECTIVE DATE: November 7, 2005.

FOR FURTHER INFORMATION CONTACT: Gladys Wheeler, (410) 786–0273.

SUPPLEMENTARY INFORMATION:

I. Background

FR Doc. 05–22026, entitled ''Medicare Program E-Prescribing and the Prescription Drug Program,'' which was published November 7, 2005 (70 FR 67568), adopted several final standards for an electronic prescription drug program under Title I of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). We have identified several technical errors in that final rule. We are correcting those errors in the Correction of Errors section below. Because these technical corrections are not substantive in nature, the effective date of the November 7, 2005, final rule is unaffected by this notice.

II. Summary of Errors

On page 67571, in the second ''Response'' of the first column, we are revising the reference to the *http://www.cms.hhs.gov/hipaa/hipaa2* Web site because, in the near future, the Frequently Asked Questions (FAQs) will be available through a link on the general CMS Web site.

On page 67571, in the last paragraph of the second column, the word ''direction'' should be replaced with the more appropriate word ''discretion.'' Also, in that same paragraph the word ''is'' should be added to the phrase ''and designed'' to improve clarity.

On page 67574, in the fourth full paragraph of the second column, the singular word ''criterion'' should have been in the plural form. Therefore, ''criterion,'', needs to be replaced with ''criteria''.

On page 67581, in the first full paragraph of the second column, the word ''may'' was inadvertently omitted.

On page 67592, in the first response of the second column, we inadvertently left language related to an initial plan to include computer-generated prescription facsimiles in the definition of electronic media after a phase-in period. We explicitly exempted computer-generated facsimiles from the requirements to use the NCPDP SCRIPT standard in the final regulatory text. Therefore, the preamble discussion of a phase-in should be deleted.

III. Correction of Errors

FR Doc. 05–22026, entitled ''Medicare Program E-Prescribing and the Prescription Drug Program,'' which was published November 7, 2005 (70 FR 67568), is corrected as follows:

1. On page 67571,

a. In the first column, fourth full paragraph, lines 9 and 10, the CMS Web site address ''(*http://www.cms.hhs.gov/hippa/hippa2*)'' is corrected to read ''(*http://www.cms.hhs.gov*).''

b. In the second column, last paragraph, first sentence,—

(1) Line 2, the word ''direction'' is corrected to read ''discretion'';

(2) Line 6, the phrase ''and designed'' is corrected to read ''and is designed.''

2. On page 67574, in the second column, in the fourth full paragraph, line 6, the word ''criterion'' is corrected to read ''criteria.''

3. On page 67581, in the second column, in the first full paragraph, line 3, the phrase ''PDPs continue'' is corrected to read ''PDPs may continue.''

4. On page 67592, in the second column, the second full paragraph, lines 11 through 23, the sentences beginning with the phrase ''We also believe that our'' and ending with the phrase ''costs associated with e-prescribing adoption'' are deleted.

IV. Waiver of Proposed Rulemaking

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** to provide a period for public comment before the provisions of a notice take effect. We can waive this procedure, however, if we find good cause that notice and comment procedure is impracticable, unnecessary, or contrary to the public