care institution, by or through the provider and are required to:

* * * * *

PART 498—APPEALS PROCEDURES FOR DETERMINATIONS THAT AFFECT PARTICIPATION IN THE MEDICARE PROGRAM AND FOR DETERMINATIONS THAT AFFECT THE PARTICIPATION OF ICFs/MR AND CERTAIN NFs IN THE MEDICAID PROGRAM

■ 1. The authority citation for part 498 continues to read as follows:

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

■ 2. In § 498.2 the definition of ''provider'' is revised to read as follows:

§ 498.2 Definitions.

* * * * *

Provider means a hospital, critical access hospital (CAH), skilled nursing facility (SNF), comprehensive outpatient rehabilitation facility (CORF), home health agency (HHA), hospice, or religious nonmedical health care institution (RNHCI) that has in effect an agreement to participate in Medicare, that has in effect an agreement to participate in Medicaid, or a clinic, rehabilitation agency, or public health agency that has a similar agreement but only to furnish outpatient physical therapy or outpatient speech pathology services, and prospective provider means any of the listed entities that seeks to participate in Medicare as a provider or to have any facility or organization determined to be a department of the provider or provider-based entity under § 413.65 of this chapter.

* * * * *

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; Program No. 93.774, Medicare—Supplementary Medical Insurance Program; and Program No. 93.778, Medical Assistance Program)

Dated: May 19, 2003.

Thomas A. Scully,

Administrator, Centers for Medicare and Medicaid Services.

Dated: August 6, 2003.

Tommy G. Thompson,

Secretary.

[FR Doc. 03–29139 Filed 11–26–03; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 408

RIN 0938–AL49

[CMS–6016–F]

Medicare Program; Reduction in Medicare Part B Premiums as Additional Benefits Under Medicare+Choice Plans

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

ACTION: Final rule.

SUMMARY: This final rule revises the regulations to provide for a Medicare+Choice organization to offer a reduction in the standard Medicare Part B premium as an additional benefit under one or more Medicare+Choice (M+C) plans. The legislation specifies that the reduction to the Medicare Part B premium cannot exceed the standard Medicare Part B premium amount and cannot be applied to surcharges. Surcharges are increased premiums for late enrollment and for reenrollment. The Medicare Part B premium may be collected by a variety of methods: Paid directly to the Centers of Medicare & Medicaid Services by the beneficiary; collected as an adjustment to any Social Security, Railroad Retirement, or Civil Service Retirement benefits; paid by an employer as part of an annuity package; or, paid by the State for individuals enrolled in a qualifying State Medicaid program. This legislation applies to benefits under Medicare M+C plans offered by an M+C organization electing this option, beginning January 1, 2003. This final rule revises the regulations to set out the basic rules under section 606 of the Medicare, Medicaid, and SCHIP Benefits Improvement Protection Act of 2000 (BIPA) for adjustment and payment of the Medicare Part B premium.

EFFECTIVE DATE: The provisions of this final rule are effective December 29, 2003.

FOR FURTHER INFORMATION CONTACT: Michele Sanders, (410) 786–0808.

SUPPLEMENTARY INFORMATION: To order copies of the **Federal Register** containing this document, send your request to: New Orders, Superintendent of Documents, P.O. Box 371954, Pittsburgh, PA 15250–7954. Specify the date of the issue requested and enclose a check or money order payable to the Superintendent of Documents, or enclose your Visa or Master Card number and expiration date. Credit card orders can also be placed by calling the order desk at (202) 512–1800 or by faxing to (202) 512–2250. The cost for each copy is $10. As an alternative, you can view and photocopy the **Federal Register** document at most libraries designated as Federal Depository Libraries and at many other public and academic libraries throughout the country that receive the **Federal Register**. This **Federal Register** document is also available from the Federal Register online database through GPO access, a service of the U.S. Government Printing Office. The Web site address is: *http://www.access.gpo.gov/nara/index.html.*

I. Background

Section 606 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) amended section 1854 (f)(1) of the Social Security Act (the Act) by allowing Medicare+Choice (M+C) organizations to elect to receive a reduction in its payment under § 422.250(a)(1), 80 percent of which would be applied to reduce (or eliminate) the standard Medicare Part B premium otherwise paid by, or on behalf of, its Medicare enrollees. This was intended to make the M+C plan more attractive to Medicare beneficiaries and increase enrollment in M+C plans.

Beneficiaries must pay a premium in order to receive Supplementary Medical Insurance benefits commonly referred to as Medicare Part B. The Part B premiums are collected monthly, most commonly as deductions from the beneficiary's Social Security or other retirement benefits. They also may be paid by a third party, such as an employer or the State Medicaid program, or are paid directly by the beneficiary.

The provisions of this final rule revising part 408 to reflect the provisions of section 606 of BIPA are described in detail in section II, Provisions of the Final Rule.

II. Provisions of the Final Rule

We are making the following revisions to 42 CFR part 408 to reflect changes in the statute made in section 606 of BIPA:

We are adding a new § 408.21 entitled ''Reduction in Medicare Part B Premium as an Additional Benefit Under Medicare+Choice Plans.'' This new provision includes paragraphs treating, respectively, the basis for a reduction of Medicare Part B premiums, the administrative requirements for a Medicare Part B premium reduction,

beneficiary eligibility, and notification of premium reductions.

In § 408.21(a), we set forth language reflecting the fact that, under section 606 of BIPA, an M+C organization may offer, as an additional benefit under an M+C plan, a reduction in the amount that an enrollee in the M+C plan pays to Medicare for the Medicare Part B premium. For the Medicare Part B premium reduction to occur, the M+C organization must accept a reduction in its monthly capitation payments under § 422.250(a)(1). The Medicare Part B premium paid by a beneficiary enrolled in an M+C plan that offers this additional benefit will be reduced by 80 percent of the amount that the capitation payment to the M+C organization is reduced. The Medicare Part B premium reduction may not exceed the standard Medicare Part B premium amount, and if the beneficiary owes less than this amount, the difference is not paid to the Medicare beneficiary.

In § 408.21(b), we set forth the administrative requirements under section 606 of BIPA for the Medicare Part B premium reductions. These requirements include: (1) The M+C capitation reduction must not result in a Medicare Part B premium reduction greater than the standard premium amount determined for the year under section 1839 of the Act (the reduction to the Medicare Part B premium may be less); (2) the Medicare Part B premium reduction will use only multiples of 10 cents; (3) the Medicare Part B premium reduction will be applied to all beneficiaries who are enrolled in the M+C plan under which the benefit is offered without regard to who actually pays/collects the Medicare Part B premium (Social Security Administration (SSA), Railroad Retirement Board (RRB), Office of Personnel Management (OPM), the beneficiary, the State, or employer); (4) The Medicare Part B premium reduction will never result in a payment to a beneficiary. (If the amount of the reduction is equal to or greater than the amount a beneficiary owes due to hold harmless premiums, the beneficiary will owe $0.)

Section 408.21(c) specifies the eligibility requirements under section 606 of BIPA for the Medicare Part B premium reduction; namely that, in order to be eligible for the reduction, a beneficiary must be enrolled in an M+C plan that offers the reduction to the Medicare Part B premium as an additional benefit.

Section 408.21(d) explains that after the Centers for Medicare & Medicaid Services (CMS) determines the Medicare Part B premium reduction amount for each eligible beneficiary, the SSA, RRB, or OPM, as applicable, will include the adjusted amount of the Medicare Part B premium in benefit check amounts as appropriate and notify the beneficiaries of their new benefit amount. The paragraph also notes that we will notify States, formal groups, and directly billed beneficiaries of each beneficiary's reduced Medicare Part B premium amounts in the regular monthly billing process.

III. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506c(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

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

There are no information collection requirements associated with this final rule. This provision is strictly voluntary and is provided as a benefit option for M+C organizations.

IV. Regulatory Impact

We have examined the impacts of this final rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1955 (Pub. L. 104–4), and Executive Order 13132.

Executive Order 12866 (as amended by Executive Order 13258, which merely reassigns responsibility of duties) 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 annually). This is not a major rule. It will have no significant economic impact on either costs or savings and may result in lower premiums for some beneficiaries.

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 $6 million to $29 million annually (*see* 65 FR 69432). Individuals and States are not included in the definition of small entities.

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 located outside of a Metropolitan Statistical Area with fewer than 100 beds.

We are not preparing analyses for either the RFA or section 1102(b) of the Act because we have determined, and we certify, that this rule will have no impact on any small entities or rural hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 requires that agencies assess anticipated costs and benefits before issuing any rule that may result in an expenditure in any one year by State, local, or tribal governments, in the aggregate, or by the private sector, of $110 million. This final rule will have a positive effect on the annual expenditures of any State, local, or tribal government, or private sector with enrollees covered under a State buy-in agreement or group payer arrangement as set forth in subpart C and E, respectively, of part 407 of this chapter; and, whose enrollees opt to enroll in a Medicare+Choice organization's (M+CO) Plan Benefit Package that offers a reduction to the Medicare Part B premium permitted as an additional benefit, authorized under section 606 of the BIPA and defined under part 422, subpart A of this chapter. Any reduction to the beneficiary's Medicare Part B premium will be applied regardless of the entity that actually pays the Medicare Part B premium on behalf of the beneficiary. The entity that actually pays the

Medicare Part B premium would receive the benefit of this reduction under this rule. If a beneficiary is paying the premium, he or she would pay a lower premium. If another entity pays the premium, they would receive the savings.

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

In accordance with the provisions of Executive Order 12866, this final rule was reviewed by the Office of Management and Budget. This final rule is not a major rule as defined at 5 U.S.C. 804(2).

V. Waiver of Proposed Rulemaking

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** and invite public comment on the proposed rule. The notice of proposed rulemaking includes a reference to the legal authority under which the rule is proposed, and the terms and substances of the proposed rule or a description of the subjects and issues involved. The notice of proposed rulemaking can be waived, however, if an agency finds good cause that notice and comment procedures are impracticable, unnecessary, or contrary to the public interest, and it incorporates a statement of the finding and its reasons in the rule issued.

Publishing a proposed rule is unnecessary in this instance, as this final rule only makes conforming changes to the regulations to implement sections of the BIPA in which the Congress allowed no discretion as to the actions to be taken and the times in which they must be completed. These changes were enacted by the Congress, and would be in effect on the date mandated by the legislation without regard to whether they are reflected in conforming changes to the regulation text, since a statute controls over a regulation. In this final rule we merely have revised the regulation text to reflect these new statutory provisions. The BIPA provisions have been incorporated virtually verbatim, with no interpretation necessary. We do not believe that publishing a notice of proposed rulemaking is necessary, nor would it be practicable given that a number of the provisions have already taken effect consistent with the effective dates established under the BIPA.

List of Subjects in 42 CFR Part 408

Medicare.

■ For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services amends 42 CFR chapter IV, part 408 as set forth below:

PART 408—PREMIUMS FOR SUPPLEMENTAL MEDICAL INSURANCE

■ 1. The authority citation for part 408 continues to read as follows:

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

Subpart B—Amount of Monthly Premiums

■ 2. Section 408.21 is added to read as follows:

§ 408.21 Reduction in Medicare Part B premium as an additional benefit under Medicare+Choice plans.

(a) *Basis for reduction in Part B premium.* Beginning January 1, 2003 an M+C organization may elect to receive a reduction in its payments under § 422.250(a)(1) of this chapter if—

(1) 80 percent of the payment reduction is applied to reduce the standard Medicare Part B premiums of its Medicare enrollees.

(2) The Medicare Part B premium is reduced monthly and is offered to all Medicare enrollees in a specific plan benefit package.

(b) *Administrative requirements for the Part B premium reduction.* (1) The Medicare Part B premium reduction cannot be greater than the standard premium amount determined for the year, under section 1839(a)(3) of the Act. However, it may be less.

(2) The Medicare Part B premium reduction must be a multiple of 10 cents.

(3) The Medicare Part B premium reduction is applied regardless of who pays or collects the Part B premium on behalf of the beneficiary.

(4) The Medicare Part B premium can never be less than zero and will never result in a payment to a beneficiary for a specific month.

(c) *Beneficiary eligibility.* In order for a beneficiary to be eligible for the Medicare Part B premium reduction, the beneficiary must be enrolled in an M+C plan that offers the Medicare Part B premium reduction as an additional benefit.

(d) *Notifications.* After determining the Medicare Part B premium reduction amount for each eligible beneficiary, CMS will—

(1) Transmit this information to the Social Security Administration, Railroad Retirement Board, or the Office of Personnel Management, as appropriate, which will adjust the benefit check amounts as appropriate and notify the beneficiaries of their new benefit amount.

(2) Notify states and formal groups and direct billed beneficiaries of their reduced premium amounts in the regular monthly billing process.

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

Dated: May 6, 2003.

Thomas A. Scully,

Administrator, Centers for Medicare & Medicaid Services.

Approved: July 28, 2003.

Tommy G. Thompson,

Secretary.

[FR Doc. 03–28718 Filed 11–26–03; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF THE INTERIOR

Office of the Secretary

43 CFR Part 4

RIN 1090–AA92

Special Rules Applicable to Surface Coal Mining Hearings and Appeals

AGENCY: Office of the Secretary, Interior.

ACTION: Final rule.

SUMMARY: The Office of Hearings and Appeals is publishing a final rule that revises an existing regulation allocating the burden of proof in a proceeding under the Surface Mining Control and Reclamation Act of 1977.

EFFECTIVE DATE: December 29, 2003.

FOR FURTHER INFORMATION CONTACT: Will A. Irwin, Administrative Judge, Interior Board of Land Appeals, U.S. Department of the Interior, 801 N. Quincy Street, Suite 300, Arlington, Virginia 22203, telephone 703–235–3750. Persons who use a telecommunications device for the deaf (TDD) may call the Federal Information Relay Service (FIRS) at 800–877–8339.

SUPPLEMENTARY INFORMATION:

I. Background

On March 20, 2003, the Office of Hearings and Appeals (OHA) published for comment a petition for rulemaking that it had received from the National Mining Association (NMA). 68 FR 13657–13661 (Mar. 20, 2003). On the basis of the decision of the U.S. Supreme Court in *Director, Office of*