actuarial value * * * of *deductible* and *coinsurance* amounts that would have applied * * * if these enrollees had not enrolled in this or another HMO or CMP.''

Section 417.532(g) states, in part, that ''HCFA will deduct these *payments* * * * in computing the payments to the HMO or CMP''.

Over the years there have been discussions about how to handle these payments within the Medicare program budgeting. There has never been any doubt that these are actual payment amounts and not actuarial representations.

Comment: Two commenters considered that the current cost report form is not adequate for full reporting.

Response: As noted above, we want to ensure the most efficient and least burdensome procedures for full reporting. This will probably require changes in the form, to be worked out during the lead time.

Comment: One commenter thought that including intermediary payments in the cost report might require the auditor that certifies the report to extend its testing procedures to include the intermediaries.

Response: This will not be necessary. The auditor will certify that the amounts reported as paid by the intermediary are part of the HMO's or CMP's incurred costs.

B. Technical Amendments

1. *Comment:* Three commenters inferred, from our proposed revision of § 417.800(c), that we intended to change our current policy of paying 100 percent of reasonable costs for services for which beneficiaries are not liable for coinsurance.

Response: That was not our intent. We have revised paragraph (c)(2)(ii) to clearly state that coinsurance is deducted only for services that are subject to coinsurance.

2. *Other changes.* We have incorporated the proposed definition of ''furnished'', and removed obsolete provisions that applied only to contract periods that began before January 1986.

C. Changes in the Regulations

1. *Definitions.* In § 417.1, we added a definition of ''furnished'' to make clear that, in part 417, the term means made a available by the HMO, CMP, or HCPP either directly or under arrangements it makes with other entities.

2. *Full reporting.* We have amended § 417.576 to make clear that the incurred per capita costs in the cost report must include the costs paid by the Medicare intermediary.

3. *Deductions from HCPP reasonable costs.* In § 417.800, we have revised paragraph (c)(2) to make clear that the 20 percent deduction from the reasonable costs incurred by the HCPP applies only to services that are subject to coinsurance.

4. *Obsolete provisions.* We have removed the following paragraphs and sections that applied to contract periods that began before January 1986:

- Paragraph (b) of § 417.546 (Physician services and other Part B services furnished under arrangements), and the Editorial note at the end of the section.
- Paragraph (d)(2) of § 417.560 (Apportionment: Part B physician and supplier services).
- All of § 417.562 (Weighting of direct services furnished by physicians and other practitioners).

D. Other Required Information

1. Information Collection Requirements

Section 417.576 requires ''full reporting'' as discussed under part D of this preamble. This requirement is subject to review by the Office of Management and Budget under the Paperwork Reduction Act of 1980, and has been submitted for their review. The time required for compiling and processing the information and completing the report with the additional costs is estimated to be 180 hours per year.

2. Regulatory Impact Statement

Consistent with the Regulatory Flexibility Act (RFA) (5 U.S.C. 601 through 612), we prepare a regulatory flexibility analysis unless the Secretary certifies that a rule will not have a significant economic impact on a substantial number of small entities. We consider all HMOs and CMPs that contract with us to furnish services to Medicare beneficiaries on a cost basis to be small entities.

In addition, under section 1102(b) of the Act, the Secretary is required to prepare a regulatory impact analysis if a rule may have a significant impact on the operation 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 small rural hospital as a hospital that has fewer than 50 beds and is not located in a Metropolitan Statistical Area.

This final rule requires HMOs and CMPs paid on a cost basis to include in their cost reports the costs of hospital and SNF services even if a Medicare intermediary processes those claims and makes payments directly to the hospital or SNF. There are approximately 25 HMOs and CMPs that have elected to have the Medicare intermediaries pay for these services. As noted earlier in this preamble, we believe that payments to these HMOs and CMPs will not be reduced significantly because of the statutory limits on the A & G costs related to inpatient hospital and SNF care paid by Medicare intermediaries.

The lead time before implementation of the full reporting requirement will enable HCFA and the affected HMOs and CMPs to work out the most efficient, least burdensome, procedures for handling these additional data. The additional costs incurred by the HMOs and CMPs for full reporting are allowable costs.

We have not prepared a regulatory flexibility analysis because we have determined, and the Secretary certifies that this final rule will not have a significant economic impact on a substantial number of small entities or a significant impact on the operations of a substantial number of small rural hospitals.

In accordance with the provisions of Executive Order 12866, this regulation was not reviewed by the Office of Management and Budget.

List of Subjects in 42 CFR Part 417

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

42 CFR part 417 is amended as set forth below.

1. The authority citation for part 417 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh), secs. 1301, 1306, and 1310 of the Public Health Service Act (42 U.S.C. 300e, 300e–5, and 300e–9) and 31 U.S.C. 9701.

2. In § 417.1, the following definition is added, in alphabetical order:

* * * * *

Furnished, when used in connection with prepaid health care services, means services that are made available to an enrollee either directly by, or under arrangements made by, the HMO, CMP, or HCPP.

* * * * *

§ 417.546 [Amended]

3. In § 417.546, the following changes are made:

a. Paragraph (b) and the Editorial note are removed.

b. In paragraph (a), the ''(a)'' designation is removed, and the ''(1)''