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. Such an 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 50 beds.

This rule merely makes a technical amendment to delay the due date for the submission, by a group of physicians that wishes to be identified as a ''group practice,'' of a statement attesting that it meets certain conditions. For this reason, 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 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 411

Kidney diseases, Medicare, Physician referral, Reporting and recordkeeping requirements.

42 CFR part 411 is amended as set forth below:

PART 411—EXCLUSIONS FROM MEDICARE AND LIMITATION ON MEDICARE PAYMENT

1. The authority citation for part 411 continues to read as follows:

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

2. In § 411.360, paragraph (e) is revised to read as follows:

§ 411.360 Group practice attestation.

* * * * *

(e) A group that intends to meet the definition of a group practice in order to qualify for an exception described in §§ 411.355 through 411.357, must submit the attestation required by paragraph (a) or paragraph (b)(1) of this section, as applicable, to its carrier no later than 60 days after receipt of the attestation instructions from its carrier.

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

Dated: November 21, 1995.

Bruce C. Vladeck,

Administrator, Health Care Financing Administration.

Dated: November 29, 1995.

Donna E. Shalala,

Secretary.

[FR Doc. 95–30064 Filed 12–8–95; 8:45 am]

BILLING CODE 4120–01–P

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42 CFR Part 424

[BPD–838–FC]

RIN 0938–AH19

Medicare Program; Additional Supplier Standards

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Final rule with comment.

SUMMARY: This final rule with comment period conforms our regulations to changes made to section 1834 of the Social Security Act (the Act) by section 131 of the Social Security Act Amendments of 1994. Section 1834(j) of the Act requires that suppliers meet additional standards related to compliance with State and Federal licensure requirements, maintaining a physical facility on an appropriate site, and proof of appropriate liability insurance. This final rule retains existing regulatory standards and incorporates the three additional standards specifically cited from the statute.

DATES: Effective Date: This rule is effective January 1, 1996.

Comments: Comments will be considered if we receive them at the appropriate address, as provided below, no later than 5 p.m. on February 9, 1996.

ADDRESSES: Mail written comments (1 original and 3 copies) to the following address: Health Care Financing Administration, Department of Health and Human Services, Attention: BPD–838–FC, P.O. Box 26676, Baltimore, MD 21207.

If you prefer, you may deliver your written comments (1 original and 3 copies) to one of the following addresses:

Room 309–G, Hubert H. Humphrey Building, 200 Independence Avenue SW., Washington, DC 20201, or

Room C5–09–26, 7500 Security Boulevard, Baltimore, MD 21244–1850.

Because of staffing and resource limitations, we cannot accept comments by facsimile (FAX) transmission. In commenting, please refer to file code BPD–838–FC. Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, in Room 309–G of the Department's offices at 200 Independence Avenue, SW, Washington, DC, on Monday through Friday of each week from 8:30 a.m. to 5 p.m. (phone: (202) 690–7890).

For comments that relate to information collection requirements, mail a copy of comments to: Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503, Attn: Allison Herron Eydt, HCFA Desk Officer.

FOR FURTHER INFORMATION CONTACT: Larry Bonander, (410) 786–4479.

SUPPLEMENTARY INFORMATION:

I. Background

A. General

The Medicare Part B program is a voluntary program that pays all or part of the costs for physicians' services, outpatient hospital services, certain home health services, services furnished by rural health clinics, ambulatory surgical centers, and comprehensive outpatient rehabilitation facilities, and certain other medical and hospital health services not covered by Medicare Part A.

Medicare services are furnished by two types of entities, that is, providers and suppliers. The term ''provider'' as defined in our regulations at 42 CFR 400.202, means a hospital, a rural primary care hospital, a skilled nursing facility, a comprehensive outpatient rehabilitation facility, a home health agency, or a hospice that has in effect an agreement to participate in Medicare. A clinic, a rehabilitation agency, or a public health agency that has a similar agreement to furnish outpatient physical therapy or speech pathology services, or a community mental health center with a similar agreement to furnish partial hospitalization services, is also considered a provider (see sections 1861(u) and 1866(e) of the Social Security Act (the Act)).

In general, suppliers are individuals or entities that furnish certain types of medical and other health services under part B. There are different definitions of the term supplier and specific regulations governing different types of suppliers. Durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) encompasses the types of items included in the definition of ''medical equipment and supplies'' found at section 1834(j)(5) of the Act. In