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]

BILLING CODE 4120–01–P

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

interest and incorporate a statement of the finding and the reasons for it into the notice issued.

We find it unnecessary to undertake notice and comment rulemaking because this notice merely provides technical corrections to the regulations. Therefore, we find good cause to waive notice and comment procedures.

(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. 05–24445 Filed 12–22–05; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare and Medicaid Services

42 CFR Part 484

[CMS–3006–F]

RIN 0938–AJ10

Medicare and Medicaid Programs: Reporting Outcome and Assessment Information Set Data as Part of the Conditions of Participation for Home Health Agencies

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

ACTION: Final rule.

SUMMARY: This final rule makes revisions in response to public comments received on the January 25, 1999 interim final rule with comment period (64 FR 3748). The interim final rule requires electronic reporting of data from the Outcome and Assessment Information Set as a Condition of Participation for home health agencies.

DATES: *Effective Dates:* This final rule is effective on June 21, 2006.

FOR FURTHER INFORMATION CONTACT: Rebecca Donnay (410) 786–1428, Patricia Sevast (410) 786–8135, Steve Miller (410) 786–6656.

SUPPLEMENTARY INFORMATION:

I. Background

A. General Legislative Background

Home health services are furnished to Medicare beneficiaries under the Hospital Insurance (Part A) and Supplemental Medical Insurance (Part B) benefits of the Medicare program, and are described in section 1861(m) of the Social Security Act (the Act). These services must be furnished by, or under arrangement with, a home health agency (HHA) that participates in the Medicare program, and must be provided on a visiting basis in the beneficiary's home.

Section 1861(o) of the Act specifies certain requirements that an HHA must meet to participate in the Medicare program. In particular, section 1861(o)(6) of the Act provides that an HHA must meet the Conditions of Participation (CoPs) specified in section 1891(a) of the Act, and any other CoPs that we find necessary in the interest of the health and safety of HHA patients. Section 1861(o)(8) of the Act provides that an HHA must meet additional requirements that the Secretary finds necessary for the effective and efficient operation of the home health program.

Section 1891 of the Act sets forth many of the conditions that HHAs must meet to participate in the Medicare program. Specifically, section 1891(a) of the Act establishes requirements for HHAs with respect to patient rights, home health aide training and competency, and compliance with applicable Federal, State, and local laws. Under section 1891 of the Act, we are responsible for assuring that the CoPs, and their enforcement, are adequate to protect the health and safety of all individuals under the care of an HHA and to promote the effective and efficient use of Medicare funds.

Under the authority of sections 1861(o), 1871, and 1891 of the Act, we have established in regulations the requirements that an HHA must meet to participate in Medicare. These requirements are set forth at 42 CFR part 484, Home Health Services. The CoPs apply to an HHA as an entity and the services furnished to all individuals under the care of the HHA, unless a condition is specifically limited to Medicare beneficiaries. Existing regulations in § 440.70(d) specify that HHAs participating in the Medicaid program must also meet the Medicare CoPs.

In accordance with sections 1864 and 1891(c) of the Act, State agencies generally conduct surveys of HHAs to determine whether they are complying with the CoPs. Section 1864 of the Act authorizes the use of State agencies to determine providers' compliance with the CoPs. Responsibilities of States in ensuring compliance with the CoPs are set forth at 42 CFR part 488, Survey, Certification, and Enforcement Procedures.

B. Legislation and Related Regulations

Section 1861(o) of the Act, as amended by section 4603 of the Balanced Budget Act of 1997 (BBA) (Pub. L. 105–33), enacted on August 5, 1997, requires us to establish a Home Health Prospective Payment System (HHPPS) for services on or after October 1, 1999. Section 5101 of the Omnibus Consolidated and Emergency Supplemental Appropriations Act for 1999 (OCESAA) (Pub. L. 105–277), enacted on October 21, 1998, delayed the implementation date of the HHPPS until October 1, 2000.

In order to implement the prospective payment system, it was necessary that we have data from HHAs to develop a reliable case-mix adjustor system. Section 4602 of the BBA provided that, for cost reporting periods beginning on or after October 1, 1997, we may require HHAs to submit additional information that we consider necessary for the development of a reliable case-mix system. The Outcome and Assessment Information Set (OASIS), the assessment instrument developed to measure patient health care outcomes in HHAs, is also a vehicle through which information is collected and used for the case-mix system.

Thus, to facilitate the implementation of the prospective payment system and to gather data to be used to evaluate and develop plans to improve outcomes of care in HHAs, we published two regulations in the **Federal Register** on January 25, 1999. The final rule, Comprehensive Assessment and Use of the OASIS as Part of the Conditions of Participation for Home Health Agencies (64 FR 3764), requires that HHAs complete a comprehensive assessment for each patient, and that they incorporate the OASIS into their current patient assessment process. In addition, we published an interim final rule with comment period to require HHAs to electronically report data from the OASIS to the State survey agency, or other entity designated by us (64 FR 3748).

The June 18, 1999, notice (64 FR 32984) in the **Federal Register** entitled ''Mandatory Use, Collection, Encoding, and Transmission of Outcome and Assessment Information Set (OASIS) for Home Health Agencies (HHAs)'', announced the effective dates for the mandatory use, collection, encoding, and transmission of OASIS data for all Medicare/Medicaid patients receiving skilled services. This notice also described the development of a new OASIS System of Records (SOR). We indicated that for patients receiving only personal care services, regardless of payer source, requirements for OASIS and the transmission of those data would be delayed until further notice. In addition, the notice announced that for non-Medicare/non-Medicaid