regulations at 42 CFR part 410, subpart H. One requirement is that entities must satisfy required quality standards. Currently, one way of satisfying the quality standards under 42 CFR 410.145 is to be approved by an approved accrediting body. The regulations pertaining to the application procedures for national accreditation organizations for DSMT are at 410.142. After we approve and recognize the accreditation organization, it may accredit an entity to meet one of the sets of quality standards described in 410.144.

II. Review Process and Findings

A. Review Process

In evaluating an application from an accrediting organization, we consider the following factors under section 1865(b)(2) of the Act:

- Accreditation requirements.
- Survey procedures.
- Ability to provide adequate resources for conducting required surveys and to supply information for use in enforcement activities.
- Monitoring procedures.
- Ability to provide us with the necessary data for validation.

We are required by 410.142(d) to publish a proposed notice in the **Federal Register** after the receipt of a written request for approval from a national accreditation organization. After review of the national accreditation organization's application, the regulations require that we publish a notice of our approval or disapproval after we receive a complete package of information and the organization's deeming application.

B. Review Findings

We received a complete application from the American Diabetes Association (ADA) on April 20, 2001. On June 27, 2001, we published a proposed notice in the **Federal Register**, (66 FR 34223) announcing the application of the ADA for approval as an accreditation program for diabetes self-management training programs. We reviewed their application to determine if the ADA used one of the sets of quality standards described in 410.144.

III. Analysis of and Responses to Public Comments and Provisions of the Final Notice

We received no public comments on our proposed notice. Therefore, we have approved the ADA's application as an accreditation program for diabetes self-management training programs under 410.142(d). The ADA is the first accreditation organization that we have approved for accrediting diabetes self-management training programs.

Authority: Section 1865 of the Social Security Act (42 U.S.C. 1395bb).

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

Dated: September 19, 2001.

Thomas A. Scully,

Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 01–26288 Filed 10–25–01; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–8012–N]

RIN 0938–ZA20

Medicare Program; Part A Premium for 2002 for the Uninsured Aged and for Certain Disabled Individuals Who Have Exhausted Other Entitlement

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

ACTION: Notice.

SUMMARY: This notice announces the hospital insurance premium for calendar year 2002 under Medicare's hospital insurance program (Part A) for the uninsured, not otherwise eligible aged (hereafter known as the ''uninsured aged'') and for certain disabled individuals who have exhausted other entitlement. The monthly Medicare Part A premium for the 12 months beginning January 1, 2002 for these individuals is $319. The reduced premium for certain other individuals as described in this notice is $175. Section 1818(d) of the Social Security Act specifies the method to be used to determine these amounts.

EFFECTIVE DATE: This notice is effective January 1, 2002.

FOR FURTHER INFORMATION CONTACT: Clare McFarland, (410) 786–6390.

SUPPLEMENTARY INFORMATION:

I. Background

Section 1818 of the Social Security Act (the Act) provides for voluntary enrollment in the Medicare hospital insurance program (Medicare Part A), subject to payment of a monthly premium, of certain persons aged 65 and older who are uninsured under the Old Age Survivors and Disability Insurance Program (OASDI) or Railroad Retirement Acts and do not otherwise meet the requirements for entitlement to Medicare Part A. (Persons insured under the OASDI or Railroad Retirement Acts and certain others do not have to pay premiums for hospital insurance.)

Section 1818(d) of the Act requires us to estimate, on an average per capita basis, the amount to be paid from the Federal Hospital Insurance Trust Fund for services performed and related administrative costs incurred in the following calendar year with respect to individuals aged 65 and over who will be entitled to benefits under Medicare Part A. We must then determine, during September of each year, the monthly actuarial rate for the following year (the per capita amount estimated above divided by 12) and publish the dollar amount for the monthly premium in the succeeding calendar year. If the premium is not a multiple of $1, the premium is rounded to the nearest multiple of $1 (or, if it is a multiple of 50 cents but not of $1, it is rounded to the next highest $1). The 2001 premium under this method was $300 and was effective January 1, 2001. (See 65 FR 62733, October 19, 2000.)

Section 1818A of the Act provides for voluntary enrollment in Medicare Part A, subject to payment of a monthly premium, of certain disabled individuals who have exhausted other entitlement. These are individuals who are not currently entitled to Part A coverage, but who were entitled to coverage due to a disabling impairment under section 226(b) of the Act, and who would still be entitled to Part A coverage if their earnings had not exceeded the statutorily defined substantial gainful activity amount (section 223(d)(4) of the Act).

Section 1818A(d)(2) of the Act specifies that the provisions relating to premiums under section 1818(d) through (f) of the Act for the aged will also apply to certain disabled individuals as described above.

Section 13508 of the Omnibus Budget Reconciliation Act of 1993 (Pub. L.103–66) amended section 1818(d) of the Act to provide for a reduction in the premium amount for certain voluntary (section 1818 and 1818A) enrollees. The reduction applies to an individual who is eligible to buy into the Medicare Part A program and who, as of the last day of the previous month—

- Had at least 30 quarters of coverage under title II of the Act;
- Was married, and had been married for the previous 1-year period, to a person who had at least 30 quarters of coverage;
- Had been married to a person for at least 1 year at the time of the person's death if, at the time of death, the person had at least 30 quarters of coverage; or
- Is divorced from a person and had been married to the person for at least

10 years at the time of the divorce if, at the time of the divorce, the person had at least 30 quarters of coverage.

Section 1818(d)(4)(A) of the Act specifies that the premium that these individuals will pay for calendar year 2002 will be equal to the premium for uninsured aged enrollees reduced by 45 percent.

II. Monthly Premium Amount for 2002

- The monthly premium for the uninsured aged and certain disabled individuals who have exhausted other entitlement, for the 12 months beginning January 1, 2002, is $319.
- The monthly premium for those individuals subject to the 45 percent reduction in the monthly premium is $175.

III. Monthly Premium Rate Calculation

As discussed in section I of this notice, the monthly Medicare Part A premium is equal to the estimated monthly actuarial rate for 2002 rounded to the nearest multiple of $1 and equals one-twelfth of the average per capita amount, which is determined by projecting the number of individuals aged 65 and over entitled to hospital insurance and the benefits and administrative costs that will be incurred on their behalf.

The steps involved in projecting these future costs to the Federal Hospital Insurance Trust Fund are:

- Establishing the present cost of services furnished to beneficiaries, by type of service, to serve as a projection base;
- Projecting increases in payment amounts for each of the service types; and
- Projecting increases in administrative costs.

We base our projections for 2002 on (a) current historical data, and (b) projection assumptions derived from current law and the Midsession Review of the President's Fiscal Year 2002 Budget.

We estimate that in calendar year 2002, 33.852 million people aged 65 and over will be entitled to benefits (without premium payment) and that they will incur $129.550 billion of benefits and related administrative costs. Thus, the estimated monthly average per capita amount is $318.91 and the monthly premium is $319. The full monthly premium reduced by 45 percent is $175.

IV. Costs to Beneficiaries

The 2002 premium of $319 is about 6.3 percent higher than the 2001 premium of $300.

We estimate that approximately 392,000 enrollees will voluntarily enroll in Medicare Part A by paying the full premium. We estimate an additional 5,000 enrollees will pay the reduced premium. We estimate that the aggregate cost to enrollees paying these premiums will increase by about $90 million in 2002 over 2001.

V. Waiver of Notice of Proposed Rulemaking

We are not using notice and comment rulemaking in this notification of Part A premiums for 2002, as that procedure is unnecessary because of the lack of discretion in the statutory formula that is used to calculate the premium and the solely ministerial function that this notice serves. The Administrative Procedure Act permits agencies to waive notice and comment rulemaking when this notice and public procedure thereon are unnecessary. Furthermore, given that we are statutorily bound to make these estimates and promulgate these rates all in the month of September, the Congress clearly did not envision the use of notice and comment rulemaking, as it is not feasible to conduct such a process in a 30-day period. On this basis, we waive publication of a proposed notice and a solicitation of public comments.

VI. Regulatory Impact Statement

We have examined the impacts of this notice as required by Executive Order 12866 (September 1993, Regulatory Planning and Review) and the Regulatory Flexibility Act (RFA) (September 19, 1980 Pub. L. 96–354). Executive Order 12866 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.) The estimated overall effect of the changes in the premium will be a cost to voluntary (section 1818 and 1818A) enrollees of about $90 million. Therefore, this notice is not a major rule under Executive Order 12866.

The RFA requires agencies to analyze options for regulatory relief of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and government agencies. Most hospitals and other providers and suppliers are small entities, either by nonprofit status or by having revenues of $5 million to $25 million (see 65 FR 69432.) For purposes of the RFA, individuals are not considered to be 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 that is located outside of a Metropolitan Statistical Area and has fewer than 100 beds.

Section 202 of the Unfunded Mandates Reform Act of 1995 also 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 notice has no consequential effect on State, local, or tribal governments or on the private sector.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. We have determined that this notice does not significantly affect the rights, roles, and responsibilities of States.

For these reasons, 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 would 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 reviewed by the Office of Management and Budget.

Authority: Sections 1818(d)(2) and 1818A(d)(2) of the Social Security Act (42 U.S.C. 1395i–2(d)(2) and 1395i–2a(d)(2)).

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance)

Dated: September 17, 2001.

Thomas A. Scully,

Administrator, Centers for Medicare & Medicaid Services.

Dated: September 27, 2001.

Tommy G. Thompson,

Secretary.

[FR Doc. 01–26702 Filed 10–19–01; 8:45 am]

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