on the nature and degree of performance. More specifically, they depend on the following:

- Relative overall performance compared to other contractors.
- Number of criteria in which nonconformance occurs.
- Extent of each major nonconformance.
- Relative significance of the requirement for which major nonconformance occurs within the overall evaluation program.
- Efforts to improve program quality, service, and efficiency.
- Deciding the assignment or reassignment of providers and designation of regional or national intermediaries for classes of providers.

We make individual contract action decisions after considering these factors in terms of their relative significance and impact on the effective and efficient administration of the Medicare program.

In addition, if the cost incurred by the intermediary, RHHI, carrier, or DMEPOS regional carrier to meet its contractual requirements exceeds the amount that we find to be reasonable and adequate to meet the cost that must be incurred by an efficiently and economically operated intermediary or carrier, these high costs may also be grounds for adverse action.

## IX. Response to Public Comments

Because of the large number of items of correspondence we normally receive on **Federal Register** documents published for comment, we are unable to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and, if we proceed with a subsequent document, we will respond to the comments in the preamble of that document.

## X. 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 Public Law 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). Since this notice only describes criteria and standards for evaluating FI's, Carriers and DMEPOS carriers and has no economic or social impact on the program, its beneficiaries or providers or suppliers, this is not a major notice.

The RFA requires agencies to analyze options for regulatory relief of small businesses. This notice does not affect small businesses, individuals and States are not included in the definition of a small business 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 notice does not affect small rural hospitals.

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. This notice does not require an impact analysis because it does not have an economic impact on small entities, small rural hospitals, or State, local, or tribal governments.

In accordance with the provisions of Executive Order 12866, this notice was reviewed by the Office of Management and Budget.

## XI. Federalism

We have reviewed this notice under the threshold criteria of Executive Order 13132, Federalism. We have determined that the notice does not significantly affect the rights, roles, and responsibilities of States.

## XII. Collection of Information Requirements

This document does not impose information collection and recordkeeping requirements. Consequently it need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*).

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

Dated: September 13, 2001.

**Thomas A. Scully,**

*Administrator, Centers for Medicare & Medicaid Services.*

[FR Doc. 01–31720 Filed 12–27–01; 8:45 am]

**BILLING CODE 4120–01–P**

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Centers for Medicare & Medicaid Services

**[CMS–2135–N]**

**RIN: 0938–AL34**

## Medicare Program; Deductible Amount for Medigap High Deductible Options for Calendar Year 2002

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

**ACTION:** Notice.

**SUMMARY:** This notice announces the annual deductible amount of $1,620 for the Medicare supplemental health insurance (Medigap) high deductible options for 2002. High deductible policy options are those with benefit packages classified as ''F'' or ''J'' that have a high deductible feature. The deductible amount represents the annual out-of-pocket expenses (excluding premiums) that a beneficiary who chooses one of these options must pay before the policy begins paying benefits.

**EFFECTIVE DATE:** January 1, 2002.

**FOR FURTHER INFORMATION CONTACT:** Kathryn McCann, (410) 786–7623.

**SUPPLEMENTARY INFORMATION:**

## I. Background

### *A. Medicare Supplemental Insurance*

A Medicare supplemental, or Medigap, policy is the principal type of private health insurance that a beneficiary may purchase to cover certain costs that Medicare does not cover. The beneficiary is responsible for deductibles and coinsurance amounts for both Part A (hospital insurance) and Part B (supplementary medical insurance) of the Medicare program. In addition, Medicare generally does not cover custodial nursing home care, eyeglasses, dental care, and most outpatient prescription drugs. A beneficiary must either pay the full cost of these services, or he or she may purchase additional private health insurance to help pay these costs. Medigap policies offer coverage for some or all of the deductibles and coinsurance amounts required by Medicare. Additionally, Medigap policies may provide coverage for some services that are not covered under the Medicare program.

Section 1882 of the Social Security Act (the Act) establishes, among other things, minimum standards for Medigap policies. No Medigap policy may be issued in a State unless the policy complies with State laws that conform to section 1882(b)(1) of the Act.

The Omnibus Budget Reconciliation Act of 1990 (OBRA 90) amended the Act by standardizing Medigap benefits and requiring that no more than 10 Medigap benefit packages, Plans ''A'' through ''J,'' be offered nationwide. Three States (Wisconsin, Minnesota, and Massachusetts) experimented with standardizing benefits before the enactment of Federal standards. These States were permitted to keep their alternative forms of Medigap standardization and are referred to as the ''waivered States.''

Plan ''A'' is the basic benefit package. It covers Medicare Part A hospital coinsurance plus coverage for 365 additional days after Medicare benefits end, over the beneficiary's lifetime, Medicare Part B coinsurance (generally 20 percent of the Medicare-approved amount or, in the case of hospital outpatient department services under a prospective payment system, the applicable copayment), and coverage for the first 3 pints of blood per year. Medigap Plans ''B'' through ''J'' contain this basic benefit package, as well as different combinations of additional benefits. Plans ''F'' and ''J'' contain:

- Medicare Part A inpatient hospital deductible.
- Skilled-nursing facility coinsurance.
- Part B deductible.
- Foreign travel health emergencies.
- 100% of Medicare Part B excess charges.

In addition, Plan ''J'' includes:

- At-home recovery.
- Some prescription drug coverage.
- Preventive care.

*B. High Deductible Medigap Policies*

Section 4032 of the Balanced Budget Act of 1997 (BBA) authorized high deductible versions of Plans ''F'' and ''J'' and their closest counterparts in the waivered States. Unlike the regular versions of Plans ''F'' and ''J,'' the high deductible versions of these policies do not begin paying benefits until the deductible amount is met. Out-of-pocket expenses that can be applied toward this deductible are expenses that would ordinarily be paid by the policy, including Medicare deductibles for Parts A and B, emergency foreign travel expenses in the case of both high deductible policies, and outpatient prescription drug costs in the case of the high deductible version of Plan J. The Plan ''F'' deductible does not include the separate foreign travel emergency deductible of $250. The Plan ''J'' deductible does not include the plan's separate $250 prescription drug deductible or the plan's separate $250 deductible for foreign travel emergencies. Even though foreign travel emergency expenses and prescription drug expenses may be applied toward meeting the plan's overall deductible, these types of expenses can only be paid after the separate $250 deductible for the benefit has been met.

**II. Provisions of This Notice**

The high deductible amount is determined in accordance with section 1882(p)(11)(C)(i) of the Act. That provision prescribed a deductible of $1500 for 1998 and 1999, and directed that the amount increase each subsequent year by the percent increase in the Consumer Price Index for all urban consumers (CPI–U), all items, U.S. city average. For 2001, the high deductible amount was $1,580. For 2002, the high deductible amount is increased by the percent increase in the CPI–U for the 12-month period ending August 2001. As reported by the Bureau of Labor Statistics, Department of Labor, the CPI–U index was 172.7 in August 2000 and 177.5 in August 2001, resulting in a 2.78 percent increase for the 12-month period ending August 2001. A 2.78 percent increase in $1,580.00 is $1,623.92. Section 1882(p)(11)(C)(ii) of the Act stipulates that this amount be rounded to the nearest multiple of $10. After rounding $1,623.92 to the nearest $10 multiple, the 2002 deductible for the Medigap high deductible options is $1,620.

**III. 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 Public Law 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 aggregate impact of this notice on beneficiaries is negligible, therefore, this is not a major notice.

The RFA requires agencies to analyze options for regulatory relief of small businesses. This notice does not effect small businesses, individuals and States are not included in the definition of a small business 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 notice does not effect small rural hospitals.

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. This notice does not require an impact analysis because it does not have an economic impact on small entities, small rural hospitals, or State, local, or tribal governments.

In accordance with the provisions of Executive Order 12866, this notice was reviewed by the Office of Management and Budget.

**IV. Collection of Information Requirements**

This document does not impose information collection and recordkeeping requirements. Consequently it need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*).

**Authority:** Section 1882 of the Social Security Act. (Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance, and Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: November 21, 2001.

**Thomas A. Scully,**

*Administrator, Centers for Medicare & Medicaid Services.*

[FR Doc. 01–31721 Filed 12–27–01; 8:45 am]

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Administration for Children and Families

**[Program Announcement No. ACYF–PA–HS–02–01B**

### Discretionary Announcement of the Availability of Funds and Request for Applications for Select Service Areas of Early Head Start; Correction

**AGENCY:** Administration for Children, Youth and Families, ACF, DHHS.

**ACTION:** Correction.

**SUMMARY:** This document contains a correction to the Notice that was published in the **Federal Register** on September 20, 2001.

On page 48474, Appendix A, Part I, in the State of Washington, in the State