§ 418.306 Determination of payment rates.

* * * * *

(b) *Payment rates.* The payment rates for routine home care and other services included in hospice care are as follows:

* * * * *

(3) For Federal fiscal years 1994 through 2002, the payment rate is the payment rate in effect during the previous fiscal year increased by a factor equal to the market basket percentage increase minus—

(i) 2 percentage points in FY 1994;

(ii) 1.5 percentage points in FYs 1995 and 1996;

(iii) 0.5 percentage points in FY 1997; and

(iv) 1 percentage point in FY 1998 through FY 2002.

(4) For Federal fiscal year 2001, the payment rate is the payment rate in effect during the previous fiscal year increased by a factor equal to the market basket percentage increase plus 5 percentage points. However, this payment rate is effective only for the period April 1, 2001 through September 30, 2001. For the period October 1, 2000 through March 31, 2001, the payment rate is based upon the rule under paragraph (b)(3)(iv) of this section. The payment rate in effect during the period April 1, 2001 through September 30, 2001 is considered the payment rate in effect during fiscal year 2001.

(5) The payment rate for hospice services furnished during fiscal years 2001 and 2002 will be increased by an additional 0.5 percent and 0.75 percent, respectively. This additional amount will not be included in updating the payment rate as described in paragraph (b)(3) of this section.

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

Dated: June 3, 2002.

Thomas A. Scully,

Administrator, , Centers for Medicare & Medicaid Services.

Dated: August 21, 2002.

Tommy G. Thompson,

Secretary.

[FR Doc. 02–29798 Filed 11–21–02; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 482

[CMS–1224–P]

RIN 0938–AM01

Medicare Program; Nondiscrimination in Posthospital Referral to Home Health Agencies and Other Entities

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

ACTION: Proposed rule.

SUMMARY: This proposed rule would establish a process for us to collect, maintain, and make available to the public, information about hospital referrals of Medicare patients to home health agencies (HHAs) and other entities with which the hospitals have a financial interest or which have a financial interest in the hospital. We would publicize this information in an effort to increase awareness regarding the availability of Medicare-certified HHAs and other entities to serve the Medicare population, and to inform beneficiaries of their freedom to choose among available Medicare-participating providers that are capable of furnishing the needed services.

DATES: We will consider comments if we receive them at the appropriate address, as provided below, no later than 5 p.m. on January 21, 2003.

ADDRESSES: In commenting, please refer to file code CMS–1224–P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission. Mail written comments (one original and two copies) to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1224–P, PO Box 8014, Baltimore, MD 21244–8014.

Please allow sufficient time for mailed comments to be timely received in the event of delivery delays.

If you prefer, you may deliver (by hand or courier) your written comments (one original and two copies) to one of the following addresses:

Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201, or

Room C5–14–03, 7500 Security Boulevard, Baltimore, MD 21244–1850.

(Because access to the interior of the HHH Building is not readily available to persons without Federal Government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and could be considered late.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT: Elizabeth Carmody, (410) 786–7533.

SUPPLEMENTARY INFORMATION: *Inspection of Public Comments:* Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone (410) 786–7197.

Copies: Additional copies of the **Federal Register** containing this proposed rule can be made at most libraries designated as Federal Depository Libraries and at many other public and academic libraries throughout the country that receive the **Federal Register**.

This **Federal Register** document is also available from the **Federal Register** online database through *GPO Access,* a service of the U.S. Government Printing Office. The Web site address is: *http://www.access.gpo.gov/nara/index.html.*

I. Background

Section 4321 of the Balanced Budget Act of 1997 (BBA), Pub. L. 105–33, was enacted by the Congress to improve the administration of the Medicare Program by enabling Medicare beneficiaries to make more informed choices about the providers from which they receive Medicare services. We believe that this provision was intended to address concerns that some hospitals were referring patients only to home health agencies (HHAs) in which they had a financial interest. Section 4321 of the BBA addresses both quality and program integrity concerns inherent in financial relationships among hospitals, HHAs, and other entities.

Section 4321(a) of the BBA requires that Medicare participating hospitals, as part of the discharge planning process, share with each beneficiary a list of

Medicare-certified HHAs that serve the beneficiary's geographic area and which request to be listed. In addition, the statute prohibits hospitals from specifying that beneficiaries receive services from a particular HHA. Further, the statute requires that hospitals identify any HHA or other entity in which they have a disclosable financial interest or which have a financial interest in them, although it does not define what is meant by ''financial interest.'' The intent of section 4321(a) is to protect patient choice. Hospitals essentially have a captive population and, through the discharge planning process, can affect who provides posthospitalization services. CMS has already implemented the requirements of section 4321(a). A CMS directive was issued on October 31, 1997, and enforcement is carried out through the hospital survey and certification process. Moreover, the requirements of section 4321(a) are set forth in the proposed hospital conditions of participation, published on December 19, 1997 (62 FR 66726).

This proposed rule would establish a process for implementing sections 4321(b) and (c) of the BBA. Section 4321(b) of the BBA requires each Medicare participating hospital to maintain and disclose to the Secretary of Health and Human Services (the Secretary) the following information:

(1) The nature of any direct or indirect financial interest that exists among the hospital and those HHAs and other entities to which the hospital refers beneficiaries under a discharge plan.

(2) The number of beneficiaries who were discharged from the hospital and who were identified as requiring home health services.

(3) The percentage of those beneficiaries who received home health services from an HHA in which the hospital has a financial relationship.

Section 4321(c) of the BBA requires the Secretary to make available to the public the information disclosed under section 4321(b).

II. Provisions of the Proposed Regulations

We are proposing a process for collecting and publicizing the information required by sections 4321(b) and (c) of the BBA.

A. Claims-Level Information

Information regarding beneficiary utilization of hospital, HHA, and other services is readily available through the secure network governing the day-to-day claims processing operations of the Medicare Program. These claims data are available at the Medicare fiscal intermediaries and carriers as well as at the Centers for Medicare & Medicaid Services. We propose to use these data to identify hospital discharges and related, subsequent home health services. Further, these data will identify the hospitals, HHAs, and other entities that furnished the Medicare services.

B. Information About Financial Interests

We propose to allow hospitals to satisfy their financial disclosure obligations under the BBA through the Medicare provider enrollment process. The Medicare provider enrollment process already collects information that identifies financial relationships between hospitals, HHAs, and other entities. For example, when applying for a provider number for billing the Medicare program, a hospital must disclose the existence and nature of financial interests in HHAs and other entities. Accordingly, for the purpose of implementing section 4321(b) of the BBA, we propose to define a reportable ''financial interest'' as any financial interest that a hospital is required to report according to the provider enrollment process, which is governed by section 1124 of the Social Security Act (42 U.S.C. 1320a–3) and its implementing regulations and manual provisions. We do not believe, however, that section 4321 of the BBA should be interpreted to mean that the mere existence of a financial relationship between a hospital and an HHA constitutes a program abuse.

To implement sections 4321(b) and (c) of the BBA without placing any additional reporting burden on Medicare providers, we propose to systemically match and report information from the provider enrollment process on financial interests among hospitals, HHAs, and other entities with information from day-to-day Medicare claims processing on the utilization of home health services. We are soliciting comments on our proposed process, as well as alternative methods for collecting and reporting data.

C. Form and Manner for Disclosing Information

Information collected under sections II.A and B of this preamble will be made available annually in January for the prior October through September period, on a hospital-by-hospital basis. For each hospital, we propose collecting and reporting: (1) The total number of hospital discharges that led to home health services; (2) the percentage of those discharged beneficiaries who received home health services from an HHA that had a direct or indirect financial relationship with the discharging hospital; (3) the name(s) of the HHA(s) and other entities for which a financial relationship with the hospital exists and for which posthospital services were furnished; and (4) the nature of the financial interest.

We will determine the most effective and efficient ways to make the required information available to the public. Consideration will be given to using websites as well as hardcopy distribution. The form and manner for making the information available will be guided by the need to reach as many beneficiaries as possible in order to assist them in making informed choices about who furnishes their health care services. As such, we invite comments as to the preferred medium for disseminating this information. We anticipate releasing the initial report during the first January that is at least 90 days after the publication of the final rule.

III. Collection of Information Requirements

This document does not impose additional 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. Information about hospital discharges and related home health services is available through Medicare claims processing systems and databases. Further, financial interest information is already available through the Medicare provider enrollment process.

IV. Response to Comments

Because of the large number of items of correspondence we normally receive on **Federal Register** documents published for comment, we are not able 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 to that document.

V. Regulatory Impact Statement

A. Overall Impact

We have examined the impacts of this rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 16, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, the Unfunded

Mandates Reform Act of 1995 (Pub. L. 104–4), and Executive Order 13132.

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 in any 1 year). This is not a major rule. It would not impose any additional costs on affected entities, as compliance with the statute and the rules proposed herein are possible through the management and disclosure of information already available to the Medicare Program. Some indeterminable benefits may result by enabling Medicare beneficiaries to make more informed choices about who furnishes their Medicare services. Therefore, no RIA is required.

The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and government agencies. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of $7.5 million or less annually. For purposes of the RFA, all hospitals, HHAs, and ''other entities'' are considered to be small entities. However, the nature of this proposed rule is such that no regulatory burden would be placed upon hospitals, HHAs, and other entities. Therefore, no regulatory relief options are considered.

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 603 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. We certify that this proposed 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. Information needed to comply with the statute is already available through the Medicare claims processing and provider enrollment systems. Therefore, no regulatory impact analysis is required.

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 1 year by State, local, or tribal governments, in the aggregate, or by the private sector, of $110 million. This proposed rule would not have an impact 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. This proposed rule would not have a substantial effect on State or local governments for the reasons noted above.

B. Anticipated Effects

1. Effects on Beneficiaries, Hospitals, HHAs, and Other Entities

The anticipated effects on Medicare's beneficiaries would be an enhanced ability to make informed choices about the care they receive from HHAs and other entities upon discharge from a hospital. There are approximately 6,000 Medicare-certified hospitals and 6,900 Medicare-certified HHAs, of which approximately 2,000 are hospital-based. At this time, we have not compiled additional data that may identify other financial relationships between hospitals, HHAs, and other entities, as further defined under the provider enrollment guidelines.

The effect of this proposed rule on hospitals, HHAs, and other entities is uncertain, but the requirements set forth in this proposed rule would place no additional burden on these providers. A possible outcome might be to influence hospital referral patterns, thus having an impact on HHAs and other entities. The information made available in compliance with the statute and this proposed rule may impact beneficiary choices about who furnishes Medicare services to them and, in turn, may have an indeterminable impact on HHAs and other entities that receive/do not receive the beneficiary's ''business'' as a result.

2. Effects on the Medicare and Medicaid Programs

This proposed rule would improve our information campaign to assist beneficiaries in their choices for health care delivery. In addition, the information made available through this proposed rule would serve to ensure that the financial interests between hospitals, HHAs, and other entities do not lead to program integrity abuses such as steering certain patients (for example, healthier patients) to certain HHAs (for example, hospital-owned). We do not believe, however, that section 4321 of the BBA should be interpreted to mean that the mere existence of a financial relationship between a hospital and an HHA constitutes a program abuse.

The effects on the Medicaid Program may be similar in that the information about financial relationships between hospitals, HHAs, and other entities would be made available to the public.

C. Alternatives Considered

We considered requiring hospitals to collect and provide the information necessary for implementation of this proposed rule. We decided to collect the information from existing sources, however, in order to create a process that would not be burdensome to the entities involved. We request comments on our proposed process as well as on alternative approaches of collecting this information. We also invite public comment on what impact provision of this information might have on home health referrals or beneficiaries' choices of providers.

D. Conclusion

As described above, this proposed rule proposes a process for implementing the statutory requirements under sections 4321(b) and (c) of the BBA. This approach would enhance the information made available to Medicare beneficiaries and reduce potential program abuses by hospitals. Further, the proposed approach for complying with the relevant statutory provisions would place no additional burden on all affected entities or on any entity, which may be indirectly affected.

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

List of Subjects in 42 CFR Part 482

Grant programs—health, Hospitals, Medicaid, Medicare, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services proposes to amend 42 CFR chapter IV, part 482 as set forth below:

PART 482—CONDITIONS OF PARTICIPATION FOR HOSPITALS

1. The authority citation for part 482 continues to read as follows:

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

2. Section 482.43 is amended by adding paragraphs (c)(6)(i) through (c)(6)(iii) to read as follows:

§ 482.43 Condition of participation: Discharge planning.

* * * * *

(c) * * *

(6) If a hospital refers a Medicare beneficiary to an HHA or another entity in which the hospital has a reportable financial interest, or the HHA or other entity has a reportable financial interest in the hospital, CMS will make available to the public the following information:

(i) The name of the hospital, HHA, or other entity and the nature of the financial interest to the hospital.

(ii) The number of beneficiaries who the hospital discharged and identified as requiring home health services.

(iii) The percentage of the referrals in paragraph (c)(6)(ii) of this section in which the hospital had financial interest in the HHA, or the HHA had a financial interest in the hospital.

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

Dated: July 3, 2002.

Thomas A Scully,

Administrator, , Centers for Medicare & Medicaid Services.

Approved: August 5, 2002.

Tommy G. Thompson,

Secretary.

[FR Doc. 02–29563 Filed 11–21–02; 8:45 am]

BILLING CODE 4120–01–P

LEGAL SERVICES CORPORATION

45 CFR Part 1611

Financial Eligibility

AGENCY: Legal Services Corporation.

ACTION: Notice of proposed rulemaking.

SUMMARY: The Legal Services Corporation (''LSC'' or ''Corporation'') proposes to amend its regulations relating to financial eligibility for LSC-funded legal services. The proposed revisions are intended to reorganize the regulation to make it easier to read and follow; simplify and streamline the requirements of the rule to ease administrative burdens faced by LSC grantees in implementing the regulaiton and to aid LSC in enforcement of the regulation; and to clarify the focus of the regulation on the financial eligibility of applicants for LSC-funded legal services.

DATES: Comments must be submitted on or before December 23, 2002.

ADDRESSES: Comments must be submitted in writing and may be sent by regular mail, or may be transmitted by fax or email to: Mattie C. Condray, Senior Assistant General Counsel, Office of Legal Affairs, Legal Services Corporation, 750 First St., NE., 11th Floor, Washington, DC 20002–4250; (202) 336–8952 (fax); *mcondray@lsc.gov* (e-mail).

FOR FURTHER INFORMATION CONTACT: Mattie C. Condray, Senior Assistant General Counsel, Office of Legal Affairs, Legal Services Corporation, 750 First St., NE., 11th Floor, Washington, DC 20002–4250; (202) 336–7 (phone); (202) 336–8952 (fax); *mcondray@lsc.gov* (e-mail).

SUPPLEMENTARY INFORMATION: Section 1007(a) of the Legal Services Corporation Act requires LSC to establish guidelines, including setting maximum income levels, for the determination of applicants' financial eligibility for LSC-funded legal assistance. Part 1611 implements this provision, setting forth the requirements relating to determination and documentation of client financial eligibility.

The current version of 1611 was adopted in 1983. In 1995, LSC published a proposed revision to part 1611 which represented a major overhaul of the regulation (60 FR 3798, January 15, 1995). The product of significant discussions and negotiation among LSC staff and representatives of the field, the proposed rule reflected an attempt to clarify and simplify the rule without changing most of the underlying policies and concepts of the rule. Following publication of the NPRM, however, no further action on the proposed revisions to part 1611 was taken. Many outstanding issues prompting the 1995 rulemaking remain extant and there are additional issues which have arisen since then. In addition, there are statutory changes which need to be incorporated into the regulation. In light of the above, the LSC Board of Directors identified 45 CFR part 1611, Eligibility, as an appropriate subject for rulemaking on January 27, 2001. On June 30, 2001, the LSC President and the Chair of the Operations and Regulations Committee of the Board of Directors made a determination to proceed with a Negotiated Rulemaking to consider amendments to part 1611. In accordance with the LSC Rulemaking Protocol, LSC published a notice in the **Federal Register** formally soliciting suggestions for appointment to the Negotiated Rulemaking Working Group from the regulated community, its clients, advocates, the organized bar and other interested parties (66 FR 46976, September 10, 2001).

After receiving submissions of interest, a Working Group was appointed. The members of the Working Group are: Legal Services Corporation, Washington, DC (represented by Mattie C. Condray, Senior Assistant General Counsel, Office of Legal Affairs; John Eidleman, Acting Vice President for Compliance and Administration; Anh Tu, Program Counsel, Office of Program Performance; and Danilo Cardona, Director, Office of Compliance and Enforcement); Legal Services Corporation, Office of Inspector General, Washington, DC (represented by Laurie Tarantowicz, Assistant Inspector General and Legal Counsel); Center for Law and Social Policy, Washington, DC (represented by Linda Perle, Senior Attorney—Legal Services); National Legal Aid and Defenders Association, Washington, DC (represented by Jon Asher, Member NLADA Regulations Committee and Executive Director of Colorado Legal Services); Legal Aid of North Carolina, Raleigh, NC (represented by George Hausen, Executive Director); Northwest Justice Project, Seattle, WA (represented by Deborah Perluss, Director of Advocacy/General Counsel); Blue Ridge Legal Services, Inc., Harrisonburg, VA (represented by John Whitfield, Executive Director); West Texas Legal Services, Fort Worth, TX (represented by Vernon Lewis, Deputy Director); Land of Lincoln Legal Assistance Foundation, Inc., Alton, IL (represented by Joseph Bartylak, Executive Director); Atlanta Legal Aid Society, Atlanta, GA (represented by Steven Gottlieb, Executive Director); and the American Bar Association's Standing Committee on Legal Aid and Indigents and Defendants (represented by Phyllis Holmen, Member SCLAID and Executive Director, Georgia Legal Services Program).

The Working Group held three meetings: January 7–8, 2002; February 11–12, 2002; and April 11–12, 2002. All three meetings were noticed in the **Federal Register** and were open to public observation. The Working Group conducted its work under the guidance of a professional facilitator. The facilitator, although selected by and under contract to LSC pursuant to LSC's Rulemaking Protocol, did not represent LSC on the Working Group and served