

Marginal tax rate (percent)	Single filing status		Any other filing status	
	Over	But not over	Over	But not over
31	\$25,000	50,000	\$25,000	50,000
33	50,000	50,000

Dated: February 14, 2000.
David J. Barram,
Administrator of General Services.
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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Part 413

[HCFA-1860-FC]

Medicare Program; Payment Amount if Customary Charges are Less Than Reasonable Costs: Technical Amendments

AGENCY: Health Care Financing Administration (HCFA), HHS.
ACTION: Final rule with comment period.

SUMMARY: In accordance with HCFA's regulatory burden reduction program, this technical regulation modifies or removes from regulations language that references the following aspects of the Medicare program:

The Lower of Cost or Charges (LCC) carryover provision; this provision was removed from HCFA regulations several years ago.

The application of the LCC principle to durable medical equipment (DME) furnished by home health agencies (HHAs); these items are now paid in accordance with a fee schedule.

DATES: Effective Date: These regulations are effective on March 23, 2000. Comments must be submitted on or before March 23, 2000.

ADDRESSES: Mail written comments (one original and three copies) to the following address ONLY: Health Care Financing Administration, Department of Health and Human Services, Attention: HCFA-1860-FC, PO Box 8013, Baltimore, MD 21244-1850.

If you prefer, you may deliver your written comments (one original and three copies) to one of the following addresses: Room 443-G, Hubert H. Humphrey Building, 200 Independence Avenue, SW, Washington, DC, or C5-14-03, Central Building, 7500 Security Boulevard, Baltimore, MD 21244-1850. Comments mailed to those addresses may be delayed and could be considered late.

Because of staffing and resource limitations, we cannot accept comments by facsimile (FAX) transmission. In commenting, please refer to file code HCFA-1860-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 443-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 5:00 p.m. (Phone (202) 690-7890).

FOR FURTHER INFORMATION CONTACT: Ward Pleines, (410) 786-4528.

SUPPLEMENTARY INFORMATION:

I. Background

While the Medicare program's Lower of Cost or Charges (LCC) principle is mandated by sections 1814(b) and 1833(a)(2) of the Social Security Act (the Act), the inclusion of the carryover provision in the regulations at 42 CFR 413.13(h) was not required by the law. When we believed that the provider community had sufficient experience with the LCC principle to warrant the elimination of the carryover provision, we amended the regulations to permit the carryover of unreimbursed costs only for cost reporting periods starting on or after January 1, 1974 (the start of the LCC principle) but before April 28, 1988 (the elimination of the carryover provision). This change was accomplished through the publication of a final regulation in the **Federal Register** at 53 FR 10077, published March 29, 1988. We now believe that sufficient time has passed since the publication of the revision eliminating the carryover provision so that it is no longer necessary to maintain any reference to the carryover provision in the regulations. Accordingly, we have deleted sections referring to the LCC carryover provision from the regulations.

Section 4062(b) of the Omnibus Reconciliation Act of 1987 (Public Law 100-203) added section 1834 to the Act. Section 1834(a) provides for payment for durable medical equipment (DME) at 80 percent of the lesser of the actual charge for the item or the payment amount recognized under the DME fee schedule. For nominal charge Home Health Agencies (HHAs), payment is

made based on 80 percent of the DME fee schedule amount. Since payment for DME provided by HHAs is no longer based on the lesser of reasonable cost or reasonable charges, the LCC principle is no longer applicable to DME provided by HHAs. Therefore, all regulation sections referring to the application of the LCC principle to DME provided by HHAs are being deleted.

II. Provisions of the Final Regulations

In § 413.13 we clarified the language, making the following changes:

In paragraph (a), we removed the definition of "provider with a significant portion of low-income patients" (the term is explained in the one place it is used), simplified the definitions of "fair compensation", and added definitions of "customary charges" "nominal charge", and "reasonable cost".

In paragraph (b)(1), we removed the last sentence and, (as throughout the section), any provisions that expired 10 or more years ago and all beginning dates earlier than 1989.

In paragraph (c), we removed paragraph (c)(2)(iii).

Wherever appropriate, we added descriptive headings to paragraph subdivisions.

We removed paragraphs (g) and (h). The paragraph (g)(2) rule (separate consideration of Part A and Part B services) which is the only part of paragraph (g) which is not obsolete now appears in paragraph (b)(1) of the section.

In § 413.134, we have removed paragraph (k) because it is no longer applicable. We have also redesignated paragraph (l) as paragraph (k).

In § 413.153, we have removed paragraph (e) because it is no longer applicable. We have also redesignated paragraph (f) as paragraph (e).

III. 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.

IV. Regulatory Impact Statement

We have examined the impact of this rule as required by Executive Order

(E.O.) 12866 and the Regulatory Flexibility Act (RFA) (Public Law 96-354). E.O. 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits, including potential economic, environmental, public health and safety effects, distributive impacts, and equity.

The RFA (5 U.S.C. 601 through 612) requires agencies to analyze options for regulatory relief for small entities. Consistent with the RFA, we prepare a regulatory flexibility analysis unless we certify that a rule will not have a significant economic impact on a substantial number of small entities. For purposes of the RFA, we treat most hospitals and most other providers, physicians, health care suppliers, carriers, and intermediaries as small entities, either by nonprofit status or by having revenues of \$5 million or less annually. Individuals and States are not included in the definition of a small entity.

Also, 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. That 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.

The Unfunded Mandates Reform Act of 1995 requires (in section 202) that agencies prepare an assessment of anticipated costs and benefits for any rule that may result in a mandated expenditure in any one year by State, local, and tribal governments, in the aggregate or by both the private sector, of \$100 million. This rule has no mandated consequential effect on State, local, or tribal governments, or the private sector and will not create an unfunded mandate.

We have not prepared a regulatory flexibility analysis because we have determined and we certify that these rules will not have a significant economic impact on a substantial number of small entities or a significant impact on the operation of a substantial number of small rural hospitals.

In accordance with the provisions of Executive Order 12866, this rule was not reviewed by the Office of Management and Budget.

We have reviewed this final rule under the threshold criteria of Executive Order 13132, Federalism. We have determined that it does not significantly

affect the rights, roles, and responsibilities of States.

V. Waiver of Proposed Rulemaking

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** and invite public comment on a proposed rule. The notice of proposed rulemaking includes a reference to the legal authority under which the rule is proposed, the terms and substance of the proposed rule and a description of the subjects and issues involved. This procedure can be waived, however, if an agency finds good cause that a notice-and-comment procedure is impracticable, unnecessary, or contrary to the public interest and incorporates a statement of the finding and its reasons in the rule issued.

The changes made by this rule are technical and editorial in nature and do not alter the substance of the regulation. It clarifies several portions of § 413.13 and removes provisions that have not been in effect for several years.

Therefore, we find good cause to waive the notice of proposed rulemaking and to issue this final rule on an interim basis. For the same reason, we believe that we have good cause to dispense with the usual 30-day delay in the effective date of a rule, and believe that this rule should become effective immediately upon publication. We are providing a 60-day comment period for public comment.

List of Subjects in 42 CFR Part 413

Health facilities, Kidney diseases, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

42 CFR part 413 is amended as follows:

PART 413—PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END-STAGE RENAL DISEASE SERVICES; OPTIONAL PROSPECTIVELY DETERMINED PAYMENT RATES FOR SKILLED NURSING FACILITIES

1. The authority citation for part 413 continues to read as follows:

Authority: Secs. 1102, 1861(v)(1)(A), and 1871 of the Social Security Act (42 U.S.C. 1302, 1395x(v)(1)(A), and 1395hh).

2. Section 413.13 is revised to read as follows:

§ 413.13 Amount of payment if customary charges for services furnished are less than reasonable costs.

(a) *Definitions.* As used in this section—

Customary charges means the regular rates that providers charge both

beneficiaries and other paying patients for the services furnished to them.

Fair compensation means the reasonable cost of covered services.

Nominal charge means a charge equal to 60 percent or less of the reasonable cost of a service.

Public provider means a provider operated by a Federal, State, county, city, or other local government agency or instrumentality.

Reasonable cost means cost actually incurred, to the extent that cost is necessary for the efficient delivery of the service, and subject to the exclusions specified in paragraph (d) of this section.

(b) *Application of the lesser of costs or charges (LCC) principle.*—(1) *General rule.* Except as provided in paragraph (c) of this section, HCFA pays providers the lesser of the reasonable cost or the customary charges for services furnished to Medicare beneficiaries. Reasonable cost and customary charges are compared separately for Part A services and Part B services.

(2) *Example.* (i) A provider's reasonable cost for covered services furnished to Medicare beneficiaries during a cost reporting period is \$125,000.

(ii) The provider's customary charges for those services is \$110,000.

(iii) HCFA pays the provider \$110,000 less the deductible and coinsurance amounts for which the beneficiaries are responsible.

(c) *Exceptions to the LCC principle.* (1) *Providers not subject to the LCC principle.*

HCFA pays the following providers the fair compensation for the services they furnish:

(i) CORFs.

(ii) Public providers that furnish services free of charge or at a nominal charge.

(iii) Any provider that requests payment of fair compensation and can demonstrate to its intermediary that a significant portion of its patients are low income and that its charges are less than costs because its customary practice is to charge patients on the basis of their ability to pay.

(2) *Services not subject to the LCC principle.* The following services are not subject to the LCC principle:

(i) *Part A inpatient hospital services.* Inpatient hospital services are not subject to the LCC principle if they are subject to either of the following:

(A) The prospective payment system under part 412 of this chapter.

(B) The rate of increase limits set forth in § 413.40.

(ii) *Facility services related to ambulatory surgical procedures*

performed in outpatient hospital departments. Facility services related to ambulatory surgical procedures performed in hospital outpatient departments are subject to the payment methodology set forth in § 413.118.

(iii) *Services furnished by a critical access hospital (CAH).* Inpatient and outpatient services furnished by a CAH are subject to the payment methodology set forth in § 413.70.

(iv) *Hospital outpatient radiology services.* Hospital outpatient radiology services are subject to the payment methodology set forth in § 413.122.

(v) *Other diagnostic procedures performed by a hospital on an outpatient basis.* Other outpatient diagnostic procedures are subject to the payment methodology set forth in § 413.122.

(vi) *Skilled nursing facility services.* Skilled nursing facility services subject to the payment methodology set forth in §§ 413.330 *et seq.*

(d) *Exclusions from reasonable cost.* For purposes of comparison with customary charges under this section, reasonable cost does not include the following:

(1) Payments made to a provider as reimbursement for bad debts arising from noncollection of Medicare deductible and coinsurance amounts, as provided in § 413.80.

(2) Amounts that represent the recovery of excess depreciation resulting from termination from the Medicare program or a decrease in Medicare utilization applicable to prior cost reporting periods, as provided in § 413.134.

(3) Amounts that result from disposition of depreciable assets, applicable to prior cost reporting periods, as provided in § 413.134.

(4) Payments to funds for the donated services of teaching physicians, as provided in § 413.85.

(5) Except as provided in paragraph (f)(2)(iii) of this section for making nominal charge determinations in special situations, graduate medical education costs.

(e) *Reductions in customary charges.* Customary charges are reduced in proportion to the ratio of the aggregate amount actually collected from charge-paying non-Medicare patients to the amount that would have been realized had customary charges been paid, if the provider—

(1) Did not actually impose charges on most of the patients liable for payment for its services on a charge basis; or

(2) Failed to make a reasonable effort to collect those charges.

(f) *Nominal charge determinations.* In determining whether a provider's

customary charges equal 60 percent or less of its reasonable costs, the following rules apply:

(1) *General rule.* The determination is based on charges actually billed to charge-paying, non-Medicare patients, and (except for clinical diagnostic laboratory tests that are paid under section 1833(h) of the Act) is made separately for Part A services and Part B services.

(2) *Determination in special situations.* (i) *Charges based on ability to pay.* For providers that have a sliding scale or discounted charges based on patients' ability to pay, the determination—

(A) Is based on charges billed to all charge-paying patients;

(B) Uses the ratio of the sliding scale charges to the provider's full customary charges; and

(C) Applies the ratio to the discounted charges to equate those charges to customary charges.

(ii) *HHA services.* In determining nominal charges for HHAs, all Part A and Part B services, with the exception of DME, are considered together.

(iii) *Graduate medical education.* When making the nominal charge determination, graduate medical education payments (or the provider's reasonable costs for that education, if supported by appropriate data) are included in reasonable costs.

§ 413.134 [Amended]

3. Section 413.134 is amended by removing paragraph (k) and redesignating paragraph (l) as paragraph (k).

§ 413.153 [Amended]

4. Section 413.153 is amended by removing paragraph (e) and redesignating paragraph (f) as paragraph (e).

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

Dated: November 2, 1999.

Michael M. Hash,

Deputy Administrator, Health Care Financing Administration.

[FR Doc. 00-3580 Filed 2-18-00; 8:45 am]

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FEDERAL EMERGENCY MANAGEMENT AGENCY

44 CFR Part 64

[Docket No. FEMA-7728]

List of Communities Eligible for the Sale of Flood Insurance

AGENCY: Federal Emergency Management Agency (FEMA).

ACTION: Final rule.

SUMMARY: This rule identifies communities participating in the National Flood Insurance Program (NFIP). These communities have applied to the program and have agreed to enact certain floodplain management measures. The communities' participation in the program authorizes the sale of flood insurance to owners of property located in the communities listed.

EFFECTIVE DATES: The dates listed in the third column of the table.

ADDRESSES: Flood insurance policies for property located in the communities listed can be obtained from any licensed property insurance agent or broker serving the eligible community, or from the NFIP at: Post Office Box 6464, Rockville, MD 20849, (800) 638-6620.

FOR FURTHER INFORMATION CONTACT: Robert F. Shea, Jr., Division Director, Program Support Division, Mitigation Directorate, 500 C Street SW., room 417, Washington, DC 20472, (202) 646-3619.

SUPPLEMENTARY INFORMATION: The NFIP enables property owners to purchase flood insurance which is generally not otherwise available. In return, communities agree to adopt and administer local floodplain management measures aimed at protecting lives and new construction from future flooding. Since the communities on the attached list have recently entered the NFIP, subsidized flood insurance is now available for property in the community.

In addition, the Associate Director of the Federal Emergency Management Agency has identified the special flood hazard areas in some of these communities by publishing a Flood Hazard Boundary Map (FHBM) or Flood Insurance Rate Map (FIRM). The date of the flood map, if one has been published, is indicated in the fourth column of the table. In the communities listed where a flood map has been published, Section 102 of the Flood Disaster Protection Act of 1973, as amended, 42 U.S.C. 4012(a), requires the purchase of flood insurance as a condition of Federal or federally related financial assistance for acquisition or