(Pub. L. 92–419). Subsequently that title was repealed by the Cooperative Forestry Assistance Act of 1978 (16 U.S.C. 2106), which consolidates the authority for all cooperative forestry programs. Section 7 of the Act, entitled Rural Fire Prevention and Control, contains the cooperative fire programs.

36 CFR Part 270 is no longer relevant to the current cooperative fire assistance programs. The proposed rule would remove the regulations from the Code of Federal Regulations. There is no need to issue new regulations since adequate assistance guidelines for all cooperative forestry programs are given in 7 CFR Part 3015, USDA Uniform Federal Assistance Regulations.

The Catalog of Federal Domestic Assistance number of the program to which the existing regulation is applicable is 10.664, Cooperative Forestry Assistance.

This rule has been reviewed under USDA regulatory review procedures and Executive Order 12291. It has been determined that this action is not a major rule and does not require a regulatory impact analysis since it merely eliminates unnecessary duplication and will have no effect on the economy. For the same reason, this action will not affect costs, prices, competition, or the ability of U.S.-based enterprises to compete with foreign-based enterprises in domestic or export markets.

The Assistant Secretary of Agriculture for Natural Resources and Environment has determined that this action will not have a significant economic impact on a substantial number of small entities and does not require a regulatory flexibility analysis under the Regulatory Flexibility Act (5 U.S.C. 601 et. seq).

In accordance with the exceptions to rulemaking procedures in 5 U.S.C. 553 and Department of Agriculture policy (36 FR 13804), it has been found and determined that advance notice and request for comments are unnecessary.

List of Subjects in 36 CFR Part 270

Fire prevention, Grant programs, Intergovernmental relations, Rural areas, Technical assistance.

Therefore, for the reasons set out in the preamble, 36 CFR Part 270 Rural Community Fire Protection is hereby removed.

John B. Crowell, Jr.,

Assistant Secretary for Natural Resources and Environment.

[FR Doc. 83-7717 Filed 3-24-83; 8:45 am]

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GENERAL SERVICES ADMINISTRATION

41 CFR Ch. 1

[FPR Temp. Reg. 68]

Special Types and Methods of Procurement: Acquisition of Leasehold Interests in Real Property

AGENCY: General Services Administration.

ACTION: Temporary regulation.

SUMMARY: This temporary regulation prescribes policies and procedures for the leasing of real property (space) by agencies pursuant to individual agency authority and authority delegated by the General Services Administration. The bases for the regulation are sections 201(a) and 205(c) of the Federal Property and Administrative Services Act of 1949. The intended effect is to establish a uniform regulation for the leasing of real property (space).

EFFECTIVE DATE: This regulation is effective April 18, 1983 or may be observed earlier, and will continue in effect until April 18, 1985.

FOR FURTHER INFORMATION CONTACT: Mr. Philip G. Read, Office of Federal Procurement Regulations, Office of Acquisition Policy, (202–523–4755).

SUPPLEMENTARY INFORMATION: In 41 CFR Chapter 1, the following temporary regulation is added to the appendix at the end of the chapter.

Federal Procurement Regulations Temporary Regulation 68

To: Heads of Federal agencies.

Subject: Leasing of real property (space)

March 14, 1983.

1. *Purpose.* This temporary regulation prescribes policies and procedures for the acquisition of leasehold interests in real property (space) by Federal agencies.

2. *Effective date.* This regulation is effective April 18, 1983 or may be observed earlier.

3. *Expiration date.* This regulation expires on April 18, 1985.

4. *Background.*

a. Policies and procedures on the acquisition of leasehold interests in real property (space) previously have been prescribed in the Federal Property Management Regulations (FPMR) for application to GSA. In addition to the lease contracts awarded by GSA, certain agencies have individual authority to enter into lease contracts and other agencies have received delegations of authority to enter into lease contracts. This temporary regulation provides necessary guidance.

b. The Federal Procurement Regulations (FPR) concern the procurement of personal property and non-personal services. The term procurement (see § 1–1.209) includes leasing.

c. Section 1–1.004-4 of the FPR provides that the regulation applies to leasehold interests in real property only to the extent explicitly specified throughout the FPR. This temporary regulation makes some additional provisions applicable to leases.

5. *Applicability.* a. The provisions of this temporary regulation apply to the procurement of leasehold interests in real property by civilian executive agencies that are subject to Title III of the Federal Property and Administrative Services Act of 1949 and by DOD, Coast Guard, and NASA, pursuant to Title 10, Chapter 137, U.S.C. within the United States, its possessions and the Commonwealths of Puerto Rico, Guam, and the Trust Territories of the Pacific. Agencies that lease real property pursuant to the requirements of this temporary regulation include those that have their own independent leasing authority and that receive delegations of authority to lease real property (space) from GSA. This regulation is issued pursuant to the authority in 40 U.S.C. 481(a) and 486(c).

b. The acquisition of leasehold interests in real property by eminent domain or donation are not covered by this temporary regulation since the FPR is limited to procurement transactions as defined in § 1–1.209.

6. *Definitions.* The terms used in this temporary regulation have the following meanings:

a. "Leasehold interest in real property" means a contract which involves the relationship of landlord and tenant and grants the Government the right of exclusive possession of real property for a definite period (hereinafter "lease").

b. "Lessor" or "landlord" means any individual, firm, partnership, trust, association, or other legal entity which leases property.

c. "Acquisition" for the purpose of this regulation means the acquisition by lease, of the right to use certain privately owned space and to receive services such as heat, air-conditioning, light and janitor services furnished by the lessor (landlord).

d. "Solicitation for offers (SFO)" means invitation for bids and requests for proposals.

e. "Fair market value (FMV)" means the highest monetary price that a property will bring if offered for sale in the open market by a seller who is willing but not obliged to sell. This offer allows a reasonable time to find a buyer who is willing but not obliged to buy, when both parties have full knowledge of all the uses to which rental property is adapted and for which it is capable of being used.

f. "Fair Market Value for Leasing Purposes (FMVLP)" means the value of a whole or part of a property to be leased by the Government, which is determined for purposes of the lease on the basis of the FMV.

g. "Overall net return" means the ratio of the net income to the lessor, before depreciation charges and taxes, to the cost of the property.

h. "Rent or rental" as used in the Economy Act means the consideration paid for the use of leased property, exclusive of the value of any special services such as heat, light, and

janitor services which may be furnished under the lease.

i. "Rent and related services" means the consideration paid for the use of leased property plus the costs of operational services, such as heat, light, and janitor services whether furnished by the lessor, the Government, or both.

j. "Fair annual rental (FAR)" means the annual monetary amount which reasonably can be expected for the agreed use of real property by lease, as established by competition in the rental market and by an appraisal. If market information is unavailable, it is the annual amount which will amortize the value of the remaining capital investment, plus a fair rate of interest return during the remaining useful life of the rented property.

k. "Small business" means a concern, including its affiliates, which is independently owned and operated, is not dominant in the field of leasing commercial real estate and has 500 employees or less (13 CFR 121.3–8).

7. *Agency procedures.* a. *Competition.* Contracts involving leases of real property (space) shall be effected on a competitive basis (formal advertising or negotiation) to the maximum practical extent. This shall include the obtaining of offers from the maximum number of qualified sources of space available which meet the minimum requirements of the Government.

b. *Formal advertising.* The use of formal advertising in connection with the leasing of real property is generally not feasible, unless a building site has been preselected and a building is to be constructed on the site in accordance with Government furnished plans and specifications for lease to the Government. When procuring by formal advertising, the provisions of Part 1–2 shall be followed.

c. *Sole-source.* Sole-source acquisitions of leased space shall be held to the smallest number practicable and shall be justified in writing by the head of the agency or his designee.

d. *Authority to negotiate.* The authority to negotiate leasehold interests in real property (space) is in 41 U.S.C. 252(c)(10). This authority provides for negotiation where it is impracticable to secure competition by formal advertising. However, other negotiation exceptions are available as follows: public exigencies, 41 U.S.C. 252(c)(2); small purchases, 41. U.S.C. 252(c)(3); and as otherwise authorized by law, 41 U.S.C. (c)(15). For DOD, NASA and the Coast Guard, the parallel provisions in 10 U.S.C., Chapter 137 apply.

e. *Findings and determinations.* The negotiation exception utilized in the acquisition of leasehold interests in real property (space) shall be supported by findings and determinations (F&D) as provided in FPR Subpart 1–3.301 and the Federal Property and Administrative Services Act of 1949 (41 U.S.C. 252(c)) and the corresponding provisions of title 10, Chapter 137 and the Defense Acquisition Regulation. The F&D that is executed to justify the use of negotiation shall be made a permanent part of the lease file. The market survey and all other relevant facts should serve as support for the F&D.

f. *Authority to lease.* (1) The Federal Property and Administrative Services Act of 1949 (40 U.S.C. 490(h)(1)), as amended, and section 1 of Reorganization Plan No. 18 of 1950 (40 U.S.C. 490, Note) authorizes the Administrator of General Services to:

(a) Acquire leasehold interests in real property (space) for use by Federal agencies (the authority is limited to leases for buildings and improvements that do not bind the Government for periods in excess of 20 years); and

(b) Delegate leasing authority to the heads of other agencies.

(2) Agencies which have statutory authority to acquire leasehold interests in real property shall do so pursuant to the provisions of Title III of the Federal Property and Administrative Services Act of 1949 (certain civilian executive agencies) and Title 10, Chapter 137 U.S.C. (DOD, NASA and Coast Guard). This temporary regulation applies to those acquisitions.

g. *Applicable laws and Executive orders.* The contracting officer is responsible, to the extent applicable, for ensuring compliance with the following laws and Executive orders.

(1) The National Environmental Policy Act of 1969 (42 U.S.C. 4321 et seq.).

(2) The Public Buildings Act of 1959 (40 U.S.C. 606).

(3) Public Buildings Cooperative Use Act of 1976 (40 U.S.C. 490 et seq.).

(4) The Rehabilitation Act Amendments of 1974 (29 U.S.C. 701 et seq.).

(5) Occupational Safety and Health Act of 1970 (29 U.S.C. 651 et seq.).

(6) Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (42 U.S.C. 4601 et seq.).

(7) Small Business Act (15 U.S.C. 631 et seq.).

(8) Executive Order 11988, May 25, 1977—Floodplain Management.

(9) Executive Order 11990, May 25, 1977—Protection of Wetlands.

(10) The Architectural Barriers Act of 1968 (42 U.S.C. 4151–4157).

(11) The Clean Air Act (42 U.S.C. 1857 et seq.) and the Federal Water Pollution Control Act (33 U.S.C. 1251 et seq.).

h. *Market surveys.* (1) Market surveys shall be made for all lease acquisitions of space and shall include:

(a) Information on the availability of space through the use of circulars or newspaper advertisements and consultations with realtors, brokers, owners, and others, as appropriate;

(b) Inspections of all offered and other available locations which meet the minimum requirements regarding quantity, quality, availability, and probable cost; and

(c) Documentation of the survey findings for each location inspected, including the reasons for unacceptability and identity of the interested parties that receive a solicitation for offers.

i. *Advertising.* (1) All new leases for 10,000 or more square feet of space shall involve public advertising for offers, e.g., newspapers and periodicals unless the contracting officer determines that such advertising will not serve to promote competition.

(2) When the Government proposes to lease a building to be constructed on a preselected site, the proposed acquisition shall be publicized (synopsized) in the Commerce Business Daily (CBD) at least 10 days prior to issuance of the SFO in accordance with Subpart 1–1.1003.

(3) Copies of each SFO shall be maintained at the issuing office until an award has been made. They shall be made available, upon request, to all individuals and firms having an interest.

j. *Solicitations for offers (SFOs).* The SFO is the basis for the entire lease negotiation process and shall be a part of the lease. SFOs shall contain the information necessary to enable the prospective offeror to prepare a proposal. SFOs shall contain a description of the space, specifications, delivery schedule, special provisions, and contract clauses. SFOs shall specify a date for the submission of offers. Any extension of time granted to one offeror shall be granted uniformly to all offerors. The initial release of SFOs normally shall be made to all prospective offerors at the same time.

(1) For leases exceeding 10,000 square feet:

(a) SFOs shall be in writing;

(b) SFOs shall contain the minimum requirements of the Government; and

(c) SFOs shall include the provisions set forth in Subpart 1–16.6 Forms of Leases for Real Property and the following provisions:

(i) Subcontracting (with small businesses) under Federal contracts (FPR Temporary Regulation 50, Supplement 3, June 18, 1982, 47 FR 27859, June 28, 1982);

(ii) Subcontracting with women's business enterprises under Federal contracts (FPR Temporary Regulation 54, Supplement 1, June 18, 1982, 47 FR 27860, June 28, 1982);

(iii) Contract disputes (FPR Temporary Regulation 55, Supplement 1, July 21, 1982, 47 FR 33693, August 4, 1982);

(iv) Accommodations for the physically handicapped (GSA's Accessibility Standard, dated October 14, 1980, or other Standard as applicable);

(v) Energy conservation (see 41 CFR 101–20.116–2 and 101–20.116–3);

(vi) Accident and fire prevention in accordance with agency standards;

(vii) Preaward Equal Opportunity Compliance Review (see 1–12.805–5 and FPR Temporary Regulation 19, September 15, 1970, 35 FR 14747); and

(viii) Description of method used to measure space.

(d) Offers will only be considered for the initial lease term unless otherwise specified.

(e) Offerors shall be required to submit offers on an annual square foot rate basis on GSA Form 1364 Proposal to Lease Space to the United States of America, or similar form, for the amount of space offered (see paragraph 9).

(f) (i) Offers will be evaluated on the basis of the lowest annual price per square foot cost to the Government for the amount of space offered and other award factors as stated in the SFO.

(ii) When different types of space are solicited, the lowest offer as to price will be determined on the basis of the composite square foot rate per year for the total amount of space offered.

(g) When lump sum payments for initial tenant alterations are solicited, the lowest offer as to price will be determined by adding to the annual square foot rate (or the composite square foot rate) the result of the lump sum amount amortized over the term of the lease (i.e., divided by number of years in the term) divided by the square footage offered.

(h) In the evaluation of offers, the following award factors may be employed to determine which offer(s) is most advantageous to the Government.

(i) First priority to offers which meet the requirements (for the handicapped) contained in the applicable Accessibility Standard.

(A) If no offer fully meets the requirements, offers which substantially meet the requirements.

(B) If no offer substantially meets the requirements, awards consistent with the other requirements of the solicitation, with due consideration to the extent offers can meet accessibility standards for entrances, elevators, toilets, and water fountains.

(ii) Susceptibility of the design of the space offered to efficient layout and good use.

(iii) Effect of environmental factors on the efficient and economical conduct of agency operations planned for the space and the safety of the visitors and occupants.

(iv) Earliest delivery date.

(v) Consistency, if a proposed development is involved in the location offered, with State, regional, and local plans and programs.

(vi) Availability of public transportation and parking spaces.

(vii) Availability of adequate food service facilities, either in the building in which the space offered is located or within reasonable walking distance as determined by the Government (normally the Government lunch period does not exceed 30 minutes).

(i) Contracting officers, acting within the scope of their appointments, are the exclusive agents of their respective agencies to enter into and administer leases on behalf of the Government in accordance with agency procedures. Each contracting officer is responsible for performing, or having performed, all administrative actions necessary for effective contracting.

(j) (i) Negotiations will be conducted with all offerors that are within the competitive range provided awards are not made without oral discussion, i.e., that are acceptable or can be made acceptable in terms of price and technical requirements.

(ii) Offerors, as a minimum, will be given an opportunity to modify their offers.

(k) Offerors that do not meet minimum requirements after the initial negotiation will be notified and dropped from further consideration.

(l) A best and final offer shall be requested from each offeror in writing and shall include an established cutoff date.

(m) Further negotiations will not take place after the cutoff date, unless negotiations are conducted with all offerors and the procedures in paragraph (l) are repeated. Information regarding the transaction will not be furnished to offerors until after the contract is awarded.

(2) For leases involving less than 10,000 square feet:

(a) SFOs need not be prepared or issued (The market survey is the most crucial aspect of the small lease program. In these actions, a comprehensive market survey is usually sufficient to provide information on available properties that meet minimum requirements);

(b) Although no SFO is issued, the contracting office must comply with the applicable provisions regarding:

(i) Subcontracting (with small business) under Federal contracts (FPR Temporary Regulation 50, Supplement 3, June 18, 1982, 47 FR 27859, June 28, 1982);

(ii) Subcontracting with women's business enterprises under Federal contracts (FPR Temporary Regulation 54, Supplement 1, June 18, 1982, 47 FR 27860, June 28, 1982);

(iii) Contract disputes (FPR Temporary Regulation 55, Supplement 1, July 21, 1982, 47 FR 33693, August 4, 1982);

(iv) Accommodations for the physically handicapped (GSA's Accessibility Standard, dated October 14, 1980, or other standard as applicable);

(v) Energy conservation (see 41 CFR 101–20.118);

(vi) Accident and fire prevention (see 41 CFR 101–20.109);

(vii) Preaward Equal Opportunity Compliance Review (see § 1–12.805–5 and FPR Temporary Regulation 19, September 15, 1970, 35 FR 14747).

(c) Contract clauses and specifications that are negotiated for services or special requirements shall be included in the lease package; and

(d) Appraisals of the fair annual rental shall be completed on GSA Form 1241–E, In-Lease Appraisal or similar form, based upon information gathered during the market survey.

(3) (a) When changes occur in the Government's requirements (either before or after receipt of proposals), the solicitation shall be amended in writing.

(b) When timeliness is essential, oral information regarding modifications may be given if:

(i) The modifications are not complex;

(ii) A record is made of the oral information;

(iii) All firms to be notified are given notice, on the same day if possible; and

(iv) The oral information is promptly confirmed by a written amendment.

(c) When modifications in space requirements occur, the following procedures apply.

(i) If proposals are not yet due, amendments shall be sent to all firms solicited.

(ii) If the time for receipt of proposals has passed, but proposals have not yet been evaluated, the amendments shall be sent to the concerns that submit offers.

(iii) If a modification is so substantial that it requires a complete revision of the solicitation, the solicitation shall be canceled and a new solicitation issued. New solicitations shall be issued to all concerns solicited originally, any concerns added to the original mailing list, and any other qualified concerns.

(4) (a) The evaluation of offers section of the SFO shall provide for the evaluation of offers:

(i) On the basis of dollars per square foot offered, and

(ii) Other award factors.

(b) All offerors must be made aware of the basis on which the award will be made by:

(i) Stating the specific award factors related to valid agency requirements, and

(ii) Applying the factors as objectively as possible to each offer.

(5) SFOs shall include the time fixed receipt of offers (see § 1–1.304).

k. *Renewal of leases.* (1) *Notification.* When a contracting officer determines that it is in the best interest of the Government to continue to lease a property, the lessor shall be notified, however, the procedures in paragraphs 7(c)-(g), (h) and (m)(1)(2) shall be followed.

(2) *Market survey.* (a) When the right to renew a lease exists, a renewal shall be based on a market survey and other applicable considerations.

(b) Surveys should focus on the prevailing rental rates for comparable space.

(3) *Reappraisal.* (a) To ensure that the rental to be paid during the renewal period will not exceed the appraised fair annual rental value (FAR) or that the net rent will not exceed the 15 percent limitation imposed by the Economy Act, consideration shall be given to the desirability of updating the original appraisal. The 15 percent Economy Act rent limitation does not apply to leases awarded on or after October 1, 1981.

(b) the updating of an original appraisal may be accomplished by means of a memorandum, unless it is obvious that sufficient changes have occurred to warrant a new appraisal.

(3) *Cancellation.* When a determination is made that a lease which has an automatic renewal clause is no longer required, the lessor will be notified in writing that the lease has been canceled.

(4) *Succeeding lease.* (a) When the right to renew a lease does not exist, an effort to continue the occupancy may be made by negotiating a succeeding (new) lease when the contracting officer determines that:

(i) The occupant agency has a continuing need for the space and proposes no significant change in the amount of space required;

(ii) The agency is satisfied with the space and proposes no substantial alterations;

(iii) The market survey indicates that the negotiated rental for the proposed succeeding lease is fair and reasonable;

(iv) A succeeding lease is in the best interest of the Government after due consideration of the prices of other available properties, relocation costs (including estimated moving costs and the estimated cost of alterations beyond those to be required in the existing space, amortized over the firm term of the lease), and other appropriate considerations; and

(v) A succeeding lease meeting all legal requirements can be negotiated.

(b) When a succeeding lease involves a noncompetitive award, the determination to contract on that basis shall be justified in writing.

(c) For succeeding leases of 10,000 square feet or less, the requirement for a market

survey will be satisfied by three telephone contacts with firms or individuals having space available for lease, or recently leased to others.

(5) *Supplemental agreements.* Supplemental lease agreements (GSA Form 276) should be limited to the amendment of existing leases which involve the acquisition of additional space or partial release of space, revisions in the terms of a lease, rental payments, payments for overtime services, and restoration settlements.

(6) *Expansion requests.* (a) When the Government is currently housed in a building under a firm term lease with time remaining and has a valid expansion need, the following criteria shall be used to determine whether it is prudent to satisfy a total requirement through a relocation.

(b) To identify availability of suitable alternative locations, market surveys shall be conducted. If the market survey reveals alternate locations which can satisfy the total requirement, an analysis shall be performed to determine whether it is in the Government's best interest to relocate. This analysis should include:

(i) The cost of the alternate space compared to the cost of expanding at the existing location;

(ii) The cost of moving; and

(iii) The cost of the unexpired portion of the firm term lease (unless a buy out or termination is possible, in which case the actual cost of such an action should be used).

(c) If no suitable alternative location is available, a noncompetitive lease may be negotiated with the current lessor to provide contiguous expansion space by supplemental lease agreement, provided the original lease term is not extended.

l. *Superseding leases.* Consideration shall be given to the execution of a superseding lease which would replace the existing lease when the changes or modifications contemplated are so numerous or detailed as to cause complications, or would substantially change the present lease.

m. *Conduct of Negotiations.* (1) Negotiations shall be confidential and shall reflect complete agreement on all items of the offer and all terms and conditions of the lease contract.

(2) A written negotiation record shall be placed in the permanent lease file.

(3) (a) An abstract of final offers shall be prepared to aid the analysis of offers received.

(b) Abstracts shall indicate the lowest offer as to price and the conformance of each offer to the SFOs.

(4) Offers shall be evaluated in accordance with the award factors specified in the SFOs in determining which offer is most advantageous to the Government.

(5) Awards shall be made to offerors whose offers are the most advantageous to the Government, price and other factors considered.

n. *Late offers, modifications of offers, and withdrawals of offers.* Offers received after the date for best and final offers will be considered in accordance with the provisions of § 1-3.802-1.

o. *Appraisal requirements.* Before the award of a lease when the annual net rental exceeds $2,000, an appraisal of the fair rental shall be obtained for the property to be leased.

p. *Award requirements.* Before making a lease award, the following actions are required:

(1) Standard for Form 1036, Statement and Certificate of Award, shall be completed and executed by the contracting officer. This statement shall contain a complete justification with an analysis of the award factors used in the evaluation process.

(2) GSA Form 367, Analysis of Values Statement (Leased Space), shall be prepared by the contracting officer and included as a part of the lease file to demonstrate that the fair rental value has been properly established.

q. *Award.* Awards will be made in writing within the time frame specified in the SFOs. If an award cannot be made within that time, the contracting officer shall request in writing, from each offeror, an extension of the acceptance period, stating a specific date of extension.

(1) *Disclosure of mistakes after award.* When a mistake in a lessor's offer is not discovered until after award, the mistake shall be handled as provided in § 1-2.406-4.

(2) *Protests against award.* Protests regarding the award of lease contracts shall be handled as provided in § 1-2.407-8.

(3) *Awards to Federal employees.* Offers to lease space received from officers or employees of the Government shall be handled as provided in § 1-1.302-3.

(4) *Contingent fees.* In order to comply with the warranty requirement of 41 U.S.C. 254(a), the requirements of Subpart 1-1.5 shall be followed.

r. *Inspection and certification.* A Government representative shall:

(1) Inspect offered space prior to acceptance and occupancy.

(2) Certify that offered space is in compliance with the Government's requirements and specification.

s. *Responsible prospective offerors.* The responsibility of prospective contractors shall be determined prior to award (see Subpart 1-1.12).

t. *Use of liquidated damages provisions in procurement contracts.* Contracts shall include liquidated damages provisions (see § 1-1.315), as appropriate.

u. *Procurement responsibility and authority.* The procurement responsibility and authority of the head of the procuring activities and contracting officers shall be in accordance with Subpart 1-1.4.

v. *Offeror(s).* (1) *Debarred, suspended, and ineligible bidders.* The policies and procedures in FPR Temporary Regulation 65, September 24, 1982 (47 FR 43692, October 4, 1982) are applicable to offerors involved in leases of real property.

(2) (a) *Representation on size of business.* A representation on the size of the prospective lessor's business (i.e., is or is not a small business) shall be obtained for all leases of real property (see § 1-1.703-1).

(b) *Certification of Nonsegregated Facilities.* A Certification of Nonsegregated Facilities (see § 1-12.803-10) must be submitted prior to the award of a contract of $10,000 or more.

(c) *Covenant Against Contingent Fees.* A certification is required of the lessor that no person(s) or selling agency has been employed to solicit a lease upon an agreement for a commission except bona fide employees or established commercial selling agencies maintained by the lessor to secure business (see Subpart 1-1.5).

(d) *Clean Air and Federal Water Pollution Control Acts.* If the contract exceeds $100,000 over the entire term including all renewal options, the lessor is required to execute (1) a certification that the facility to be utilized in the performance of the proposed lease has or has not been listed on the EPA list of Violating Facilities and (2) a contract clause that a violating facility will not be utilized in the performance of the lease (see Subpart 1-1.23).

w. *Bonds and insurance.* Bid guarantees, performance bonds, and payment bonds may be required for lease contracts (see Subparts 1-10.1 and 1-10.2).

x. *Lease forms.* The use of standard forms is required for lease contracts as follows:

(1) Standard Form 2, U.S. Government Lease for Real Property, and

(2) Standard Form 2-A, General Provisions, Certification and Instructions (U.S. Government Lease For Real Property), for all leases. (See 1-16.601(b).)

y. *Economy Act.* The Economy Act (Section 322 of the Act of June 30, 1932 as amended by Section 15, Title II, of the Act of March 3, 1933 (40 U.S.C. 278a)) provides as follows:

(1) *Background.* (a) After June 30, 1932, no appropriation shall be obligated or expended for the rent of any building or part of a building to be occupied for Government purposes at a rental in excess of the annual rate of 15 percent of the fair market value (FMV) of the rented premises at the date of the lease under which the premises are to be occupied; nor for alterations, improvements, and repairs of the rented premises in excess of 25 percent of the amount of the rent for the first year, or for the rental term if less than one year. Effective October 1, 1981, the 15 percent limitation on rent has been waived for all leases on or after that date. The 25 percent limitation on alterations remains in effect.

(2) *Certificate of necessity.* During a war or a national emergency declared by the Congress or by the President, the Economy Act limitations do not apply to leases or renewals of existing leases of privately or publicly owned property as are certified by the Secretary of the Army, Navy, or the Air Force, or by such person or persons as they may designate, as covering premises for military, naval or civilian purposes necessary for the prosecution of the war or vital in a national emergency. (40 U.S.C. 278(b); (c 353, Title II, Sec. 205(a), and Sec. 207(f), 61 Stat. 501 and 503); (Secretary of Defense Transfer Order No. 14, June 4, 1948, and No. 40, July 22, 1949).

(a) When space is vital in a national emergency and the amount to be expended for rent or for repairs, alterations, and improvements exceeds the limitations of the Economy Act, a Certificate of Necessity is required.

(b) The amount specifically stated in the Certificate of Necessity, or the request for such certification, may not be exceeded unless the certificate is amended to authorize the excess expenditure. When repairs, alterations, and improvements are involved, the request for the certificate shall not include any items which are not within the purview of the Economy Act.

(c) Reassignment of space to another agency is the same as a new lease. Consequently, the unexpended balance of the amount, authorized by a Certificate of Necessity for the alternation of the space for the initial agency may not be extended to another agency occupying the space when such alteration costs exceed the limitations of the Economy Act.

8. *Agency inspection.* Periodic inspections by GSA leasing personnel will be performed on a random basis in order to determine that agencies with delegated-leasing authority are in compliance with this FPR Temporary Regulation.

9. *Availability of forms.* Forms may be obtained as follows:

a. GSA Forms 367, Analysis of Values Statement (Leased Space); 1364, Proposal to Lease Space to the United States of America; 276, Supplemental Lease Agreement; and 1241–E, In-Lease Appraisal, by submitting a written request to the Regional GSA Administrative Services Division Director.

b. Standard Form 2, U.S. Government Lease for Real Property; 2–A, General Provisions, Certification and Instructions, U.S. Government Lease of Real Property; and 1036, Statement and Certificate of Award, by submitting a requisition in FEDSTRIP/MILSTRIP format to the GSA regional office providing support to the requesting activity. The appropriate national stock number should be included on the requisition, 7540–00–634–3958 for SF 2, 7540–00–900–7101 for SF 2–A, and 7540–00–634–4210 for SF 1036.

10. *GSA leasing handbook.* The GSA handbook, "Acquisition of Leasehold Interests in Real Property," PBS P 1600.1A, dated June 22, 1981, is available. It may be used as an additional source of information and guidance. It is not intended that it be considered regulatory.

(Sec. 205(c), 63 Stat. 390; 40 U.S.C. 486(c))

Ray Kline

Acting Administrator of General Services.

[FR Doc. 83-7735 Filed 3-24-83; 8:45 am]

BILLING CODE 6820-61-M

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41 CFR Part 101–47

[FPMR Amendment H–138]

Surplus Real Property Disposal; Holding Agency Disposal Authority

AGENCY: General Services Administration.

ACTION: Final rule.

SUMMARY: In order to avoid confusion that has been experienced in the past, the General Services Administration is clarifying the disposal authority delegated to holding agencies.

DATE: March 25, 1983.

FOR FURTHER INFORMATION CONTACT: James H. Pitts, Office of Real Property (202–535–7067).

SUPPLEMENTARY INFORMATION: The Administrator of General Services is authorized to delegate certain authorities to heads of other agencies under the Federal Property and Administrative Services Act of 1949, as amended (63 Stat. 378; 40 U.S.C. 471 et seq.), and other applicable laws. One such authority designates the holding agency as disposal agency regarding the disposal of certain surplus real property. This proposed rule reflects the concern of Congress that it is the responsibility of the General Services Administration (GSA), not the holding agency, to dispose of federally owned machinery and equipment which are fixtures being used by a contractor-operator where the machinery and equipment will be sold to the contractor-operator. In this regard, it is also the responsibility of GSA, not the holding agency, to provide an explanatory statement of the circumstances of each disposal by negotiation of any real or related personal property having a fair market value in excess of $1,000 to the appropriate committees of Congress in advance of such disposal.

GSA received one response to the proposed revision, published in the **Federal Register** on August 5, 1982, 41 CFR Part 101–47, page 33993. The Department of Energy's (DOE) comments are abstraced as follows:

1. The revision is confusing.

2. Definitions are lacking.

3. The revision might affect disposal authorities expressly given in other statutes.

Points of clarification in response to these comments are set forth below:

1. GSA does not view the revision as confusing. In fact, the DOE comments indicate that the revision and its applicability were correctly interpreted by that agency. As expressed in the DOE comments, the revision excepts major plant equipment and machinery, (i.e. fixtures), sold to contractor-operators from the delegation of disposal authority to holding agencies.

2. The terms "fixtures", "Government-owned machinery and equipment" and "contractor-operator" are considered to be self-explanatory terms.

3. Nothing in this regulatory revision abridges or infringes authorities expressly given in other statutes. Chapter 101–47.301–3 of Title 41 CFR applies with regard to this particular concern.

GSA has determied that this rule is not a major rule for the purposes of Executive Order 12291 of February 17, 1981, because it is not likely to result in an annual effect on the economy of $100 million or more; a major increase in costs to consumers or others; or significient adverse effects. GSA has based all administrative decisions underlying this rule on adequate information concerning the need for, and consequences of, this rule; has determined that the potential benefits to society from this rule outweigh the potential costs and has maximized the net benefits; and has chosen the alternative approach involving the least net cost to society.

List of Subjects in 41 CFR Part 101–47

Surplus government property, Government property management.

PART 101–47—[AMENDED]

Accordingly, 41 CFR Part 101–47 is amended to read as follows:

Subpart 101–47.3—Surplus Real Property Disposal

1. Section 101–47.302–2(a)(2) is revised to read as follows:

§ 101–47.302–2 Holding agency.

(a) * * *

(2) Fixtures, structures, and improvements of any kind to be disposed of without the underlying land with the exception of Government-owned machinery and equipment, which are fixtures being used by a contractor-operator, where such machinery and equipment will be sold to the contractor-operator.

* * * * *

(Sec. 205(c), 63 Stat. 390; 40 U.S.C. 486(c))

Dated: March 3, 1983.

Ray Kline,

Acting Administrator of General Services.

[FR Doc. 83-7736 Filed 3-24-83; 8:45 am]

BILLING CODE 6820-96-M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 400, 405, 408, 409, 430, and 440

Medicare Program; Hospital Insurance Entitlement and Benefits

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Final rule.

SUMMARY: These regulations implement thirteen legislative amendments concerning (1) entitlement of aged or

disabled persons to Medicare, (2) requirements for receiving posthospital skilled nursing facility care and home health services, (3) determination of the deductible and coinsurance amounts for which a beneficiary is responsible, and (4) enrollment of individuals who must pay a monthly premium for Medicare. They also clarify, reorganize and renumber a major portion of our existing Medicare regulations.

EFFECTIVE DATE: These regulations are effective April 25, 1983.

FOR FURTHER INFORMATION CONTACT: Luisa V. Iglesias (202) 245-0383.

SUPPLEMENTARY INFORMATION:

I. Background

These final regulations are based, in part, on a Notice of proposed rulemaking published on May 30, 1980 (45 FR 36443). The May 1980 proposal had a threefold purpose:

1. To implement section 332(a)(3) of the Social Security Amendments of 1977 (Pub. L. 95-216) which affects entitlement based on disability;
2. To make administrative changes in the policies that apply to entitlement based on end-stage renal disease;
3. To simplify, clarify and renumber the regulations that pertain to eligibility and entitlement for hospital insurance and the benefits available under this program (Medicare Part A).

Since the May 1980 proposal, there have been twelve self-explanatory statutory amendments that affect the hospital insurance regulations. The statutory effective dates for these amendments range from December 1, 1980 to January 1, 1982.

The changes required by these amendments, and those that were proposed on May 30, 1980 are brought together in these final regulations. All the changes from current regulations, and the comments received in response to the May 30 publication are discussed below.

II. Changes To Implement Statutory Provisions That Affect Entitlement Based on Disability

The proposed regulations published in May contained a change to implement section 226(e)(4) of the Social Security Act, added by section 332(a)(3) of the Social Security Amendments of 1977 (Pub. L. 95-216). Section 226(e)(4) provides that a disabled widow or widower may be deemed entitled to monthly disability benefits retroactively for up to 12 months before filing an application for those benefits even though payment of the monthly benefits themselves may not be retroactive. The purpose of this provision is to enable the individual to count those earlier months toward the 25 months of disability entitlement required for entitlement to hospital insurance. The final regulations (§ 408.12(c)(4)) retain this provision as it appeared in the proposed rules.

Public Law 96-265, the Social Security Disability Amendments of 1980, contains two provisions that also affect entitlement of disabled persons to Medicare benefits and that are now included in these regulations. Section 103 of that law makes it easier to fulfill the Medicare entitlement requirement of having completed the 25 months of disability entitlement. Under section 103, it is no longer necessary that the 25 months be consecutive. Months in previous periods of disability entitlement (ending within specified time limits) may count toward the required 25 months.

Section 104 of Pub. L. 96-265 provides that entitlement to Medicare benefits will continue for up to 24 months after disability entitlement ends if—

- Disability entitlement ends because the disabled individual engaged in, or demonstrated the ability to engage in, substantial gainful activity; and
- The individual continues to be otherwise eligible for disability benefit entitlement.

The purpose of the amendments is to encourage disabled persons to return to work. Section 103 makes it easier to become reentitled to Medicare benefits if the disabled person has to stop working. Section 104 permits the disabled person to retain Medicare entitlement for up to 2 years after he or she loses disability benefit entitlement because of work.

We have amended the regulations as follows:

1. In §§ 408.5 and 408.12(d), relating to Medicare entitlement, we have removed the requirement that the 25 months of entitlement to disability benefits must be consecutive.
2. In § 408.12 we have added:

- A new paragraph (b) to provide for counting months of previous periods of entitlement or deemed entitlement to disability benefits toward the 25-month requirement; and
- A new paragraph (e) to provide for continuation of Medicare entitlement for up to 24 months when disability benefit entitlement ends because of substantial gainful activity.

Since the obvious intent of section 103 of Pub. L. 96-265 is to provide Medicare to disabled individuals as of their 25th month of entitlement to disability benefits (whether or not the months are consecutive), we are also amending the regulations on supplementary medical insurance (Medicare Part B) to conform to the change in the hospital insurance (Medicare Part A) regulations. Revised § 405.210 provides for automatic enrollment in Part B as of the individual's first month of Part A entitlement based on entitlement to disability benefits, even if he or she was not entitled to monthly disability benefits in the first month of the initial enrollment period (that is, the first day of the third month preceding the month he or she became eligible for Part A).

III. Changes To Implement Statutory Provisions Relating to Entitlement Based on Eligibility for Social Security Benefits

Section 2 of Pub. L. 96-473, enacted on October 19, 1980, contains a provision that enables an individual who is age 65 or older and eligible for monthly social security benefits to establish entitlement to hospital insurance benefits without having to apply for monthly social security benefits. Pub. L. 96-473 became effective on January 1, 1981.

Previously, individuals age 65 and over who met the eligibility requirements for receiving monthly social security benefits had to apply for and become entitled to those benefits before they could become entitled to Medicare. Under that requirement, individuals who were eligible for social security benefits, but who chose not to file for and receive these benefits (for example, because they wished to continue to work) were denied entitlement to Medicare. Pub. L. 96-473 changed that situation. We have amended §§ 408.6 and 408.10 of the recodified regulations to specify that an individual may apply for, and become entitled to, Medicare based on eligibility for social security cash benefits, as contrasted with actual entitlement to those cash benefits.

This new provision is retroactive. Any individual who lost Medicare entitlement because he or she withdrew an application for monthly social security benefits before January 1, 1981, will be considered to have applied only for Medicare and will be reentitled (unless he or she objects) beginning with the month his or her previous period of Medicare entitlement began. The Social Security Administration will contact these individuals and advise them of their rights and that they may have their Medicare entitlement reinstated.

We will reimburse Medicare providers for any covered services furnished to an individual who would have been entitled to Medicare when the services were furnished. (The provider will refund any payment made by, or on behalf of, the individual in accordance with current policy stated in

42 CFR Part 489). If we collected money from an individual who withdrew his or her application after we paid benefits on his or her behalf, we will refund the amounts collected.

IV. Changes To Implement the Omnibus Reconciliation Act of 1980 (Pub. L. 96-499) and the Omnibus Budget Reconciliation Act of 1981 (Pub. L. 97-35)

The Omnibus Reconciliation Act of 1980, enacted December 5, 1980, and the Omnibus Budget Reconciliation Act of 1981, enacted on August 13, 1981, contained provisions that affect Medicare eligibility, benefits, reimbursement, and administration. The provisions relating to Medicare Part A eligibility and benefits that have been incorporated in these regulations are discussed below.

Home Health Benefits

Section 930 of Pub. L. 96-499 liberalized home health benefits under Medicare by—

- Removing the 100-visit limitation;
- Deleting the requirement that home health services must be needed for a condition for which inpatient hospital or skilled nursing facility (SNF) care was received, and furnished under a plan of treatment established within 14 days after discharge from the hospital or SNF (the law still requires a plan, but does not set a time limit); and
- Adding need for occupational therapy (as well as need for intermittent skilled nursing services or physical or speech therapy, already included in the law) as a condition qualifying for receipt of home health services.

Section 2122 of Pub. L. 97-35 modified the third provision by eliminating occupational therapy as a basis for initial qualification for home health services but allowing continuing need for occupational therapy to qualify a beneficiary for continuing home health services when he or she no longer required intermittent skilled nursing care or physical or speech therapy.

These provisions of section 930 and 2122 are reflected in the changes made in §§ 409.5, 409.42(b), (c), (d) and (f), and 409.61(d).

Presumed Coverage

Section 941 of Pub. L. 96-499 deleted the presumed coverage provisions. Those provisions are discussed below in connection with the comments received on the presumed coverage portion of the proposed rules published in May 1980. Section 941 is implemented by deleting § 409.48 of the proposed rule.

Enrollment Provisions

Section 945 of Pub. L. 96-499 liberalized enrollment for Medicare Part B and, indirectly, for individuals who can become entitled to Medicare Part A only by enrolling and paying a monthly premium. These are individuals who have attained age 65 but are not eligible for social security cash benefits. Under previous law, an individual could not enroll more than twice, and there was an annual general enrollment period that lasted from January 1 to March 31 of each calendar year. Section 945 amended sections 1837, 1838, and 1839 of the Act to remove the two-enrollment limitation and establish an unlimited general enrollment period that began when the individual's initial enrollment period ended. (The initial enrollment period is a 7-month period beginning 3 months before the month the individual first meets the eligibility requirements for Medicare and ending with the third month after that first month of eligibility.)

The changes made by section 945 meant that individuals could reenroll as many times as they wished and could do so in any month, not just during January, February, or March. Section 945 was effective April 1, 1981. Section 2151 of Pub. L. 97-35 eliminated open enrollment, (that is, restored the annual 3-month enrollment period) effective October 1, 1981 but retained the provision allowing an unlimited number of reenrollments. Since the law requires that the monthly premium be increased for individuals who enroll after expiration of their initial enrollment periods and for those who reenroll, the enrollment provisions of sections 945 and 2151 also affected the way the premium increase would be determined. This is shown in §§ 408.23 and 408.24 of the regulations.

Posthospital SNF Care

Section 950 of Pub. L. 96-499 liberalizes posthospital SNF care by allowing 30 days (instead of 14) after discharge from a hospital for a beneficiary to be admitted to a SNF and receive needed care that is related to the hospital stay. These changes are also discussed as part of the discussion of comments received in response to the proposed rules published in May 1980. The section 950 changes are included in §§ 409.30(b) and 409.36(a).

Retroactive Entitlement

Section 1011 of Pub. L. 96-499 limits to 6 months the retroactivity of applications for certain types of social security benefits and leaves the previous 12-month retroactivity provision in effect for others. Of the groups affected by section 1011, only those who have attained age 65 can also be eligible for Medicare Part A. Medicare entitlement based on entitlement to social security benefits is subject to the 6-month limitation. For the sake of consistency, we are extending the 6-month limitation to applications for hospital insurance based on eligibility for social security benefits available at age 65. This means that an application that is filed within 6 months after the month in which the individual attains age 65 will be deemed to have been filed in the month he or she attained that age, and Medicare entitlement will begin with that month. However, if the application is filed more than 6 months after the month of attainment of age 65, it will be deemed to have been filed in the 6th month before the month of filing, and entitlement will begin in that 6th month. This change is included in § 408.6(d)(4) of the regulations.

Deductibles and Coinsurance

Section 2131 of Pub. L. 97-35 provides that the applicable inpatient hospital deductible amount shall be the amount in effect for the calendar year in which the inpatient hospital services are furnished. It also provides that the applicable coinsurance amounts shall be based on the deductible in effect for the calendar year in which services are furnished. (Under previous law, the applicable deductible and coinsurance amounts were the amounts determined for the year in which the benefit period began.) Section 2132 of Pub. L. 97-35 increases from $40 to $45 the base figure used to determine the inpatient hospital deductible. These provisions are effective January 1, 1982. The changes required by section 2131 are reflected in the deletion of proposed § 409.80(b)(3), and the provisions of §§ 409.82(a), 409.83(a), and 409.85(a). The formula for determining the deductible is not discussed in the regulations but the effect of section 2132 is reflected in the deductible and coinsurance amounts for calendar years 1982 and 1983, set forth in §§ 409.82(b), 409.83(b), and 409.85(b).

"Swing-bed" Provision

Section 904 of Pub. L. 96-499 (commonly referred to as the "swing-bed" provision) provides that certain small rural hospitals may enter into agreements under which they may use their inpatient hospital facilities to furnish the type of care ordinarily furnished in skilled nursing facilities and receive Medicare reimbursement for this care. The swing-bed provision was

implemented by final regulations published on July 20, 1982 (47 FR 31318). Those regulations amended two sections (§§ 405.116 and 405.120) that are being redesignated by these regulations. The conforming changes required by the swing-bed provision are reflected in §§ 409.10, 409.20 through 409.31, 409.36, and 409.85.

V. Waiver of Notice and Opportunity for Public Comment

As indicated in the preceding discussion, several of the provisions implemented by these regulations were enacted after the notice of proposed rulemaking was published in May 1980. For the reasons indicated below, we believe that we are justified in publishing them as final regulations.

Sections 103 and 104 of Pub. L. 96–265 are so specific as to preclude alternative interpretations, were effective December 1, 1980, and are advantageous to disabled persons. Section 2 of Pub. L. 96–473 is equally specific, effective on January 1, 1981, and advantageous to aged persons.

The changes made by Pub. L. 96–499 and Pub. L. 97–35 are also specific. The extension of time between hospital discharge and admission to a SNF was effective December 5, 1980; the change in retroactivity, on March 1, 1981. The changes that liberalize home health services were effective July 1, 1981.

With respect to provisions of Pub. L. 96–499 that are repealed or modified by Pub. L. 97–35, clear understanding is possible only by presenting the whole picture, that is, the rules that apply while the first amendments were in effect and those that apply when the provisions of the second law go into effect. The two other provisions of Pub. L. 97–35 (sections 2131 and 2132) are effective January 1, 1982.

In light of the effective dates and specific nature of the statutes, we find that there is good cause to—

- Make the regulation changes applicable as of the statutory effective dates of the amendments that required those changes; and
- Waive notice of proposed rulemaking procedures as unnecessary and contrary to the public interest.

VI. Changes That Apply to Persons With End-Stage Renal Disease

Three changes that apply to individuals with end-stage renal disease (ESRO) included in the NPRM are adopted as they were proposed. The first responds to comments received on final regulations published on September 28, 1978 (43 FR 44803). The other two are the result of further analysis of the impact of those regulations.

1. Under current rules, entitlement normally begins 3 months after the patient initiates dialysis, but may begin as early as the first month for a patient who is being trained for self-dialysis. The change made by § 408.13(e)(4)(iii) provides entitlement for a patient who begins self-dialysis training but dies before the end of the 3-month waiting period. The purpose of this change is to enable Medicare to pay for the part of training that was completed and for treatment furnished during that period. This will protect the facility against loss and the patient's family against medical debts.

2. The second change requires that self-dialysis training be provided by a facility specifically approved by HCFA to provide such training. (See § 408.13(e)(4)(i).) The decision to approve or disapprove would be based on the recommendation of the State survey agency, that is, the State agency that is under contract with HCFA to survey entities and recommend whether they meet the requirements for participation in the Medicare program. This requirement will ensure that self-dialysis training meets quality and safety standards.

3. The third change requires that anyone who seeks entitlement on the basis of ESRD must file an application. Pub. L. 95–292 added the requirement that ESRD patients must file application for Medicare. (Under the Act, such application may not be retroactive for more than 12 months.) Implementing regulations (42 CFR 405.104) were published on September 28, 1978 (43 FR 44802), to be effective October 1, 1978. The preamble to those regulations indicated that an application was not required for those who had ESRD before October 1, 1978. On further consideration, we realized that the intent of the law was to require an application (with its attendant 12-month limitation on retroactivity) for all ESRD patients who first sought to establish entitlement to Medicare after the effective date of the amendment. Section 408.13(c) is consistent with the basic purpose of the ESRD program, i.e., to enable individuals to obtain currently needed care, rather than to pay (or to reimburse patients who paid) for medical care received many years in the past. This policy is also necessary to preclude potential inequity. For example, without the uniform 1-year limit on retroactivity, an individual who had ESRD in July 1974 but delay filing until July 1980 could become entitled retroactively for 6 years. An individual who developed ESRD in November 1978 but did not file an application until July 1980 could become entitled retroactively for only 1 year, to July 1979. To avoid hardship on persons who had ESRD before October 1, 1978, and became eligible for Medicare, without filing an application, between October 1, 1978, and the present time, we intend to make the filing requirement effective 30 days after publication of these regulations. Anyone seeking entitlement after that date must file an application, regardless of when the diagnosis of ESRD was made.

In addition, a fourth change included in the NPRM would have deleted the provision that permitted an application to be filed on behalf of an ESRD patient after his or her death. This provision was put into effect in October 1978, along with the requirement to file an application. We proposed the deletion because we believed there was no specific statutory authority for the policy. After further review of the statute and consideration of the policy's effect on ESRD beneficiaries, we have decided to withdraw the proposed deletion. The nature of end-stage renal disease is such that potential beneficiaries may, for a legitimate reason, occasionally fail to file an application for benefits prior to their death. For this reason, we believe that posthumous applications are appropriate, and therefore the policy in effect as of October 1978 that allows an application for benefits to be filed on behalf of a deceased ESRD patient is still applicable.

VII. Clarification of Current Regulations

We have reviewed the existing regulations on Medicare entitlement with a view to achieving the following objectives—

- Remove provisions that are outdated or unnecessary;
- Eliminate duplications and correct inconsistencies;
- Define frequently used terms;
- Use shorter sentences and simpler language;
- List and number separate provisions;
- Organize the material in logical order;
- Eliminate most internal cross references; and
- Provide paragraph captions to help readers find the particular subjects that interest them.

These revised regulations supersede a major portion of Subpart A of Part 405 and establish two new parts. Part 408 sets forth the policies on eligibility and entitlement. Part 409 specifies the scope of benefits, limitations on these benefits,

and the deductible and coinsurance amounts for which a beneficiary is responsible. (The sections of Part 405, Subpart A, that are not included in this revision deal with conditions for payment of hospital insurance benefits.) Each of the two new parts begins with a brief explanation of the legal basis and scope of the part and definitions of frequently used terms. There are fewer definitions than there were in the proposed Parts 408 and 409 because we are using this document to establish a new Part 400, Subpart B which presents, at the beginning of Chapter IV, definitions that are commonly used in connection with Medicare or Medicaid, or both. The purpose is to provide easier access for users of the regulations and to avoid repetition of the same basic definitions in each part or subpart in which those terms are used.

For regulations that apply to Medicare Part A benefits, clarification was particularly needed with respect to the limitations on psychiatric care and the blood deductible.

Limitations on Psychiatric Care

Sections 409.62 and 409.63 clarify that there is a 190-day lifetime limitation on inpatient psychiatric hospital care, and that benefits during the initial benefit period are reduced if the individual was receiving inpatient psychiatric hospital care on his or her first day of entitlement and had received such care during any of the immediately preceding 150 days. They delete similar provisions that formerly applied to inpatient care in tuberculosis hospitals but were repealed by the 1967 amendments to the Social Security Act (Section 146(a) of Pub. L. 90–248).

Blood Deductible

Sections 409.80–409.87 clarify policy on deductibles and coinsurance. Rules dealing with the blood deductible:

- Specify that it applies to the first three units of whole blood or units of packed red blood cells and that it does not apply to other blood components or to the costs of processing, storing, and administering blood;
- Set forth criteria for satisfying the blood deductible by a replacement offer.

A replacement offer is acceptable if the replacement blood meets the applicable criteria specified in Food and Drug Administration regulations under 21 CFR Part 640, i.e., the blood would not endanger the health of the recipient and the blood donation would not endanger the health of the prospective donor. The facility may not charge the beneficiary for any of the first three units of whole blood or units of packed red blood cells for which it receives a replacement offer, even if it or its blood supplier rejects the offer.

This change is necessary to ensure that beneficiaries actually have the option (provided by the law) of replacing the first three units of whole blood or packed red blood cells from any sources available to them. Because current regulations do not specify the criteria for an acceptable blood replacement offer, some providers have rejected offers for other reasons, such as the inconvenience of dealing with several different blood suppliers. The specific criteria set forth in the amended regulations will protect beneficiaries from arbitrary rejection of replacement offers.

The final regulations also make clear that the provider may not charge the beneficiary for the first 3 units of whole blood or packed red blood cells if it obtained that blood or red blood cells at no charge except a processing or service charge. In that situation, the blood or red blood cells is deemed to have been replaced. Since the deductible applies only to the cost of the blood or red blood cells itself, Medicare pays the processing or service charge for all whole blood or red blood cells furnished to a beneficiary.

VIII. Discussion of Comments and Changes Responsive to Comments

The proposed recodification published on May 30, 1980, provided 60 days for comment. During that 60-day period we received 11 letters, from the American Red Cross, the American Association of Blood Banks, the American Association of Homes for the Aging, the New York Chapter of the American Physical Therapy Association, the Dallas Visiting Nurse Association, a legal services project, a State Health Department, three hospitals, and one physical therapist. The respondents were primarily concerned with the provisions on replacement of the first three units of whole blood or packed red blood cells and with the "level of care" requirements for coverage of posthospital skilled nursing facility (SNF) services. There was also some confusion as to the intent of the "presumed coverage" provisions.

Replacement of Blood

The American Red Cross (ARC), the American Association of Blood Banks (AABB), and general hospital commented on this provision.

Comment: The ARC commended the proposed clarification and observed that, if all blood were obtained from voluntary donors, beneficiaries would no longer have to pay for the first three units of blood and the Medicare program would realize substantial savings in charges for all blood furnished after the first three units.

Response: We agree that the implementation of an all-voluntary blood replacement system would result in savings to beneficiaries and to the program. However, under the current system, changes in the regulations are needed to protect the rights of Medicare beneficiaries to replace, or arrange for the replacement of, the first 3 units of whole blood or packed red blood cells so that they need not pay for them.

Comment: AABB and the director of the general hospital objected to the provision that a provider may not charge the beneficiary if a valid replacement offer is made even if the provider or its blood supplier rejects the offer. The director of the general hospital recommended that the charge to the beneficiary be waived only when an offer is made *and* accepted.

The AABB also objected to the provision on the following grounds:

1. There is no basis in the law for this provision. There is a significant difference between "arrangements have been made for replacement" (specified in section 1866(a)(2)(C) of the Act as a condition for not charging the beneficiary) and the mere "replacement offer" of the regulations. AABB believes that the language of the law refers only to arrangements in which the provider acquiesces. A "replacement offer" does not require acquiescence and therefore does not cancel the beneficiary's obligation to pay the provider for the first three units.

2. An offer by a major blood supplier to replace blood on behalf of Medicare beneficiaries is actually an offer to sell blood, since that supplier charges providers an amount which is often greater than what the providers pay their regular blood suppliers. These additional costs are passed on to the Medicare program.

3. It is costly, time-consuming, and burdensome for a provider to accept a replacement offer from a blood bank other than the one with which it normally deals.

4. Blood received from a supplier with which the provider does not normally deal is generally too old to be made into components and in fact may be so close to being outdated that it cannot be used.

5. The proposed regulation conflicts with 42 CFR 405.1028(j) (which requires providers to have "facilities for procurement, safe-keeping and transfusion of blood products") because the proposed regulation would interfere with a provider's system for procuring needed blood on an orderly basis.

Response: 1. We believe that the regulation (§ 409.87(c)) properly implements section 1866(a)(2)(C) of the Act and is fully consistent with the intent of Congress in enacting the provision. This intent is spelled out in the legislative reports that preceded enactment of the original Medicare legislation (House Report No. 213 and Senate Report 404, Part I, 89th Congress, 1st Session). The reports state with regard to the blood deductible: "The committee included this deduction provision in the interest of the voluntary blood replacement programs which encourage donations of blood by waiving charges for blood *which the patient arranges to replace*" (page 28 of Senate Report and page 25 of House Report with italic added).

The language of the committee reports indicates that it was the intent of this statutory provision that the replacement of blood through voluntary blood replacement programs relieve beneficiaries of the responsibility of paying for deductible blood, and that the replacement "arrangements" contemplated were not limited to those in which there is an agreement between the provider and a blood assurance plan. Thus, section 1866(a)(2)(C) of the law gives the beneficiary an unqualified option of either paying for the blood or arranging for replacement by whatever source he or she can, e.g., a relative, a friend or a blood replacement plan. To permit the hospital to reject a beneficiary's replacement offer would give it veto power over this option, thus effectively depriving the beneficiary of the right to obtain relief from the obligation to pay the nonreplacement fee. Such a rule would also tend to discourage membership by Medicare beneficiaries in blood replacement plans which have the same aim as the Medicare blood deductible provision—the encouragement of voluntary blood donations.

2. and 3. We recognize that some blood assurance plans charge providers for blood furnished on behalf of a Medicare beneficiary. However, we do not agree that charging a reasonable blood processing fee is equivalent to selling blood or that such a plan cannot be viewed as making a bona fide replacement offer of deductible blood on behalf of a Medicare beneficiary.

4. We do not believe that the age of blood replaced by blood suppliers will be a serious problem. The country's two major blood banking organizations require that blood shipped by member blood bank must be no more than 5 days old when shipped unless otherwise agreed to by the receiving facility.

5. We see no conflict between the regulation and 42 CFR 405.1028(j). This standard of the Medicare conditions of participation for hospitals does not proscribe hospitals from accepting blood from blood banks with which they do not have an agreement. It merely requires that facilities for procurement, safekeeping and transfusion of blood and blood products be "provided or readily available" and that a hospital which depends on outside blood banks have "an agreement governing procurement, transfer and availability of blood * * *."

A provider that has such an agreement with respect to the bulk of its blood supply is not precluded from accepting blood on occasion from other sources as circumstances may require, e.g., if it cannot obtain sufficient blood from its regular supplier or if a beneficiary wishes to replace deductible blood through arrangements with his or her own sources.

Coverage of Posthospital Extended Care Services in a SNF

Legal Assistance to Medicare Patients (LAMP), the American Physical Therapy Association (APTA), and the American Association of Homes for the Aged (AAHA) commented on this portion of the regulations, which sets forth the four essential requirements for coverage of posthospital SNF care:

- There must have been a previous hospital stay of at least 3 days.
- Discharge from the hospital must have occurred while the patient was entitled to Medicare Part A benefits.
- The need for posthospital SNF care, admission to the SNF, and receipt of SNF care must occur within a specified period of time after discharge from the hospital, except when the patient's condition does not permit initiation of this care until later.
- The care needed must be of a specified level and must be needed on a daily basis.

While final regulations were under development, section 950 of Pub. L. 96-499 modified these provisions to:

- Allow 30 days instead of 14 days (after discharge from a hospital) to be admitted to a SNF and receive needed SNF care; and
- Delete the extension (from 14 to 28 days) previously allowed when a SNF bed was not available.

Comment: LAMP objected to the requirement (§ 409.30(b)) that the individual be in need of extended care services on the date of admission. It pointed out that the law requires only that he or she need the services within 14 days after discharge from the hospital.

Response: We agree the proposed language was confusing and have revised it to clarify the policy and to implement the change made by Section 950 as follows:

- Posthospital SNF care is covered only for days when the beneficiary needs and receives care of the level described in § 409.31.
- The beneficiary must—

a. Receive the SNF care within 30 days after the date of discharge from the hospital; or

b. Receive the SNF care at a later time when his or her medical condition permits initiation of an active course of treatment. Under this provision, the need must be predictable at the time of discharge. An example would be a patient with a broken hip, who would need physical therapy but might not be able to initiate that therapy until more than 30 days after discharge from the hospital.

The amendments became effective on December 5, 1980. The new requirements have been incorporated into §§ 409.30(b) and 409.36(a).

Comment: LAMP also objected to the language in § 409.31(b)(2) which indicates that, as a condition for meeting the level of care requirement, skilled nursing or skilled rehabilitation services must be needed for treatment of a condition for which the beneficiary received inpatient hospital services or "which arose while the beneficiary was receiving *SNF* care [which implies a skilled level of care] for a condition treated in the hospital" (italics and brackets added). LAMP pointed out that the provision appears to require that the individual be receiving skilled care before he or she needs it.

Response: We concur that the proposed language could be misconstrued. We have changed the phrase "was receiving SNF care" to "was receiving care in a SNF", to make clear that the condition requiring covered posthospital SNF care could arise while the individual was receiving care that did not meet the level of care requirements. For instance, the individual could have been receiving rehabilitative services that were not covered under Medicare because they were needed 3 or 4 times a week instead of daily.

Comment: In addition, LAMP considered that the level of care requirement specified in § 409.31(b)((3) encourages evaluation of the individual's skilled care needs through isolation of particular medical services rather than consideration of the individual's total condition and overall needs.

Response: This section states the general rule, that the skilled services must be services that, as a practical matter, can be provided only in a SNF and on an inpatient basis. Criteria for applying this requirement in individual cases are set forth in § 409.35 and specifically require consideration of the patient's general condition.

Comment: The APTA objected to the requirement that the individual must need the skilled services "on a daily basis" (§ 409.31(b)(1)) and to the statement that "a break of one or two days does not preclude coverage" (§ 409.34(b)) because, in a one-person physical therapy department—

- The services may not be available 7 days a week; and
- Vacation time, sick time, or time for continuing education would preclude coverage in accordance with the cited statement.

Response: These regulations implement the requirement of section 1814(a)(2)(C) of the Act, that services must be needed on a daily basis. Accordingly, Medicare does not pay for an SNF stay unless the individual receives the care he or she needs. If the patient needs physical therapy services and these are temporarily unavailable from the facility's regular staff, the facility is expected to ensure that the patient's need is met from some other qualified source.

Comment: The APTA also objected to the $100-a-year limitation on services furnished by a physical therapist in independent practice.

Response: That limitation is imposed by section 1833(g) of the Act (which was amended by section 935 of Pub. L. 96–499 to raise the limit to $500 a year) and implemented by other regulations, at § 405.232(c)(2). Section 409.35 merely cites this limitation in an example. Under the level of care requirements, Medicare pays for inpatient SNF care only if it finds that, as a practical matter, the services can be provided only on an inpatient basis. The example makes clear that, if a physical therapist in independent practice can provide the needed services to the beneficiary, the fact that Medicare cannot pay for them (because of the statutory limitation) is not a basis for finding that the services can be provided only on an inpatient basis.

Comment: The AAHA expressed the hope that the recodification was not our answer to those who have urged a complete review of the level of care concept, for Medicaid as well as Medicare.

Response: The current level of care policies, including SNF level of care, are under review by our Long Term Care Policy Group. Because of the significance and complexity of these policies, the review is expected to require considerable time. In the interm, we believe it is necessary to carry out our recodification project to simplify and clarify existing regulations and to make the other changes described in this preamble.

Presumed Coverage Policy

The presumed coverage policy set forth in § 405.33 of current regulations was required by law (sections 1814 (h) and (i) of the Act) as one way of lessening the problems created for beneficiaries by retroactive denials of coverage. It constituted a liberalization which permitted the physician (at his or her option) to certify that the SNF care or home health services qualified for presumed coverage and thus ensure that Medicare would not question the need for at least the *minimum* number of SNF days or home health visits that experience had shown were usually required for certain medical conditions. (However, an adverse decision of a utilization review committee or a Professional Standards Review Organization would supersede the certification of presumed coverage.) Days and visits beyond that minimum, up to the maximum allowed by law, were also covered if the physician certified the need for them, a Professional Standards Review Organization or a utilization review committee had not determined that the care was not medically necessary or appropriate, and all other requirements were met.

Comment: The APTA, the Visiting Nurse Association (VNA) of Dallas, and a physical therapist made comments indicating a misinterpretation of the intent of this policy, which had been in effect since 1976 and was not changed at all by the recodification. In general, they equated "presumed coverage" with "maximum coverage" and accordingly found the number of days of SNF care or of home health visits totally inadequate and well below what the law allows. They also raised questions about the meaning of certain terms and why certain kinds of services were excluded from presumptive coverage.

Response: These comments and questions became moot when Section 941 of Pub. L. 96–499 repealed the presumed coverage provision effective January 1, 1981. As indicated above, § 409.48, which would have recodified § 405.133, has been deleted from the final regulations.

Miscellaneous Comments

The three general hospitals, the State health department, and the APTA also commented on other aspects of the regulations as follows:

1. *Limitations on amounts and kinds of benefits.*

Comment: One hospital director stated that the lifetime limit of 190 days of psychiatric care (§ 409.62) discriminates against individuals with mental illness and prevents facilities from giving the best possible care to Medicare patients.

Response: The limitation is imposed by the law (section 1812(b) of the Act) and reflects Congressional views on the most cost-effective use of the limited funds available to pay for medical care.

Comment: Another hospital suggested that we allow for more than 100 days of posthospital SNF care (per spell of illness), perhaps through a lifetime reserve similar to that provided for inpatient hospital days. It noted that, if the individual remains in the SNF, the "spell of illness" (called "benefit period" in the revised regulations) is never broken and he or she cannot become entitled to another 100 days.

Response: The 100-day limitation (§ 409.61) is imposed by section 1812(a) of the Act and cannot be changed unless the law is changed. With regard to the comment on breaking a spell of illness, we are currently reviewing whether the statute permits a different approach than the one set forth in our current regulations.

Comment: The APTA recommended that we provide for food and transportation which, in some situations, are essential to prevent having to hospitalize a patient.

Response: The law does not provide for Medicare coverage of meals in the home or of transportation, except for ambulance services when required by the patient's condition. The Congressional Committee reports which accompanied the original Medicare legislation specifically state that food service arrangements, such as meals-on-wheels programs, and transportation would not be paid for under the program. Subsequently, proposals to extend coverage to these services were considered and rejected.

2. *Other diagnostic or therapeutic services.*

Section 409.16 of the regulations permits a hospital to "arrange" for other entities to provide certain diagnostic or therapeutic services and to bill Medicare for those services if they are services of the kind that a hospital

ordinarily furnishes directly or "under arrangements".

Comment: The APTA asked who decides what services are services "ordinarily furnished" by a hospital.

Response: The general rule is that each hospital decides what diagnostic and therapeutic services it will furnish directly and what services it will furnish under arrangements with an outside source. The intermediary then determines, on the basis of the hospital's practice and in accordance with applicable HCFA guidelines, which services that particular hospital ordinarily furnishes.

3. *Definition of "skilled" services.*

Comment: A State health department expressed concern because the definition of "skilled nursing and skilled rehabilitation services" (§ 409.31) states that skilled services may be provided under the supervision of a licensed practical nurse (LPN), whereas requirements appearing elsewhere appear to mandate supervision by a registered nurse (RN).

Response: The writer may be thinking about the conditions of participation for SNFs, which require that the director of nursing services be an RN (42 CFR 405.1124). The definition is correct. Medicare pays for a skilled nursing or skilled rehabilitation service furnished to a patient if it is supervised either by an RN or by an LPN.

IX. Technical Changes and Redesignation Tables

Throughout this regulation, we have made a number of corrections, conforming changes, and minor editorial revisions in the May 30 proposed rule. We are also including, as an aid to readers, a redesignation table showing where each section of the old regulations is now located.

X. Impact Analysis

Executive Order 12291

Executive Order 12291 requires that a regulatory analysis be prepared for a rule that is likely to result in an annual effect on the economy of $100 million or more; a major increase in costs or prices for consumers, individual industries, government agencies, or geographic regions; or significant adverse effects on business or employment.

We have determined that only one of these regulations will affect the economy by more than $100 million. That provision implements section 2132 of Pub. L. 97-35, concerning the amount of the inpatient hospital deductible. Although this provision is expected to result in savings of more than $100 million for fiscal years 1982 and 1983, a regulatory analysis is not required because the change is mandated by Congressional action. This notice merely announces the change required by law in the base figure used for computing the inpatient hospital deductible.

The redesignation itself has no impact. The anticipated effect of changes made to implement statutory amendments is as follows:

Pub. L. 96-265—Changes to encourage disabled individuals to return to work (by providing for retention of Medicare entitlement for up to 2 years after they start working and making it easier to become reentitled if they again become disabled).

This is the most costly of the statutory amendments, expected to increase Medicare costs by $47 million in FY 1982.

Pub. L. 96-473—Allows entitlement to Medicare without having to apply for social security cash benefits.

No significant cost implications.

Pub. L. 96-499—Omnibus Reconciliation Act of 1980.

Section 930, which would liberalize home health benefits, is the only Pub. L. 96-499 provision implemented by these regulations that is expected to increase program costs more than a negligible amount. Sections 941 (deletion of the presumed coverage provision), 945 (open enrollment), 950 (allowing 30 instead of 14 days after hospital discharge for the individual to be admitted to a SNF and receive needed posthospital SNF care), and 1011 (limiting retroactivity of applications to 6 months instead of 12 months), are expected to have little, if any, impact.

The anticipated overall impact of the home health benefits liberalization required by section 930 was a $52 million increase in program costs for 1982: $12 million as a result of removing the 3-day prior hospital or SNF stay requirement; $5 million as a result of removing the 100-visit limitation, and $35 million as a result of including need for occupational therapy as qualifying the beneficiary to receive home health services. The estimates of costs for the unlimited visits and occupational therapy changes included the cost impact under Part B of Medicare, which also pays for home health services. (Savings of $2 million to $4 million a year were anticipated in Medicaid costs for 1982, because of increased Medicare benefits to individuals who are entitled under both programs.) Under the modification of the occupational therapy provision by section 2122 of Pub. L. 97-35 the program cost increase is estimated to be only $8 million for FY 1982, and $9 million for FY 1983.

Pub. L. 97-35, the Omnibus Budget Reconciliation Act of 1981: Other changes.

Section 2131 applies the deductible and coinsurance amounts that are in effect when the services are furnished rather than when the benefit period began. This is expected to save $5 million for fiscal year 1982 and $10 million for fiscal year 1983.

Section 2132—Increases from $40 to $45 the base figure used to determine the amount of the inpatient hospital deductible for the ensuing year.

This is the only statutory amendment that is expected to have a major impact. Estimated savings are $185 million in 1982 and $305 million in 1983.

Regulatory Flexibility Act of 1980 (Pub. L. 96-354)

This act requires a regulatory flexibility analysis for any regulations that will have a significant economic impact on a substantial number of small entities. The requirement does not apply to regulations that were published as proposed before January 1, 1981. Therefore, no analysis is required for the regulations based on the May 1980 proposal. For policies not included in that proposal, as indicated above, the only three provisions with measurable impact are those that affect individuals directly: entitlement based on disability, liberalization of certain home health benefit requirements, and the increase in the base figure used to determine the inpatient hospital deductible. Liberalization of home health benefits will have a positive impact on home health agencies since it makes benefits more readily available to Medicare beneficiaries. The increase in the amount of the inpatient hospital deductible and the hospital and SNF coinsurance will be borne by the beneficiaries and will not affect the providers. Accordingly, we find that a regulatory flexibility analysis is not required.

List of Subjects

42 CFR Part 400

Medicare, Medicaid.

42 CFR Part 405

Administrative practice and procedure, Certification of compliance, Clinics, Contracts (Agreements), End-Stage Renal Disease (ERSD), Health care, Health facilities, Health maintenance organizations (HMO), Health professions, Health suppliers, Home health agencies, Hospitals, Inpatients, Kidney diseases, Laboratories, Medicare, Nursing home, Onsite surveys, Outpatient providers,

Reporting requirements, Rural areas, X'rays.

42 CFR Part 408

Aged, Disabled, Eligibility, End-Stage renal disease (ESRD), Health Insurance, Medicare.

42 CFR Part 409

Blood, Health insurance, Home health, Hospitals, Inpatients, Medicare, Nursing homes.

42 CFR Part 430

Aid to Families with Dependent Children, Contracts (Agreement), Grant-in-Aid program—health, Health facilities, Medicaid, Medicare, Supplemental Security Income (SSI).

42 CFR Part 440

Clinics, Dental health, Drugs, Grant-in-Aid program—health, Health care, Health facilities, Health professions, Hearing disorders, Home health services, Inpatients, Laboratories, Language disorders, Lung diseases, Medicaid, Mental health centers, Occupational therapy, Personal care services, Physical therapy, Prosthetic devices, Outpatients, Opthalmic goals and services, Rural areas, Speech disorders, X-rays.

REDESIGNATION TABLE.—PART 405, SUBPART A

Old Sec.	New Sec.
405.101(a)	409.3.
405.101(b)	deleted.
405.102	408.10.
405.103	408.11.
405.104	408.13.
405.105	408.12.
405.106 (a) & (b)	408.20.
405.106 (c) & (c)(1)	408.21.
405.106(c)(2)	408.25.
405.106(c)(3)	Deleted as unnecessary. § 405.210 clearly applies only to individuals already entitled to Hospital Insurance. Reference to § 405.106 must be deleted from § 405.205.
405.106(d)	408.22.
405.110(a)	Deleted as inaccurate and unnecessary.
405.110(a) (1) & (2)	409.61(a)(1).
405.110(b)	409.3.
405.110(c)(1)	Deleted as outdated.
405.110(c)(2)	Deleted as redundant.
405.110(d)	409.62(a).
405.111 Uncoded introduction.	Deleted as unnecessary.
405.111(a)	409.63(a).
405.111(b)	Deleted as outdated.
405.111 (c) & (d)	409.63(a).
405.112	409.64.
405.113	409.80.
405.114	409.87.
405.115	409.82.
405.116	409.10.
405.116(a)	409.10.
405.116(b)	409.11.
405.116(c)	409.12.
405.116(d)(1)	409.13.
405.116(d)(2)	409.14.
405.116(e)	409.16.
405.116(f)	409.15.
405.116(g) and (h)	409.18.
405.117	409.89.

REDESIGNATION TABLE.—PART 405, SUBPART A—Continued

Old Sec.	New Sec.
405.118(a) language through "paragraph (c) of this section".	409.65(b).
405.118(a) remaining language.	409.65(a).
405.118(b)	409.65(c).
405.118(c)	409.65(d).
405.118(d)	409.65(e).
405.119	409.66.
405.120(a)(1) words "he was an inpatient for not less than 3 consecutive days".	409.30(a).
405.120(a)(1) all other words	Deleted because mostly cross-references or duplicative of content of § 409.30.
405.120(a)(2) First 2 sentences.	Deleted as outdated.
405.120(a)(2) Last sentence	Deleted as unnecessary. The cited § 405.152 takes care of the matter.
405.120(b)(1)	Deleted because 100-day limitation is explained in § 409.61(b).
405.120(b)(2)	409.32.
405.120(b)(3)	Deleted because the specifics of the cited sections are incorporated in § 409.31.
405.120(c)	409.30(a).
405.120(d)(2) Words through the 3rd and final October 30, 1972".	Deleted as unnecessary. Since (d)(1), which dealt with admissions *before* 10/30/72, was deleted, there is only one set of requirements.
405.120(d)(2) remaining words through (d)(2).	409.30(b).
405.120(d)(3) Words through the parenthetical statement.	Deleted as unnecessary (a calendar day is a calendar day).
405.120(d)(3) Remaining words.	409.32.
405.120(e) Deductible and coinsurance amount.	§§ 409.80 and 409.82.
405.122	409.64.
405.123	409.87.
405.124	409.85.
405.125	409.20.
405.126 Uncoded introduction.	Deleted as unnecessary.
405.126 (a) & (b)	409.31.
405.127(a)	409.31.
405.127(b)	409.32.
405.127 (c) & (d)	409.33.
405.128	409.34.
405.128a	409.35.
405.130	409.44
405.131 Uncoded introduction (and specifics taken from 405.236).	409.40(a).
405.131(a)–(f)	409.40(b).
405.133	Deleted because Section 941 of Pub. L. 96–499 revoked the presumed coverage provisions of the Act.
405.151	409.69.
405.161	409.68.
405.180	408.30.
405.181	408.31
430.1	400.200 and 400.203.

42 CFR Chapter IV is amended as set forth below:

A. The table of contents of Subchapter A is revised to read as follows:

CHAPTER IV—HEALTH CARE FINANCING ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES

SUBCHAPTER A—GENERAL PROVISIONS

Part

400 Introduction; Definitions

401 General Administrative Requirements

402 [Reserved]

403 Special Programs and Projects

404 [Reserved]

* * * * *

B. A new Part 400, consisting of Subpart B, is added to read as follows:

PART 400—INTRODUCTION; DEFINITIONS

Subpart A—[Reserved]

Subpart B—Definitions

Sec.

400.200 General definitions.

400.202 Definitions specific to medicare.

400.203 Definitions specific to medicaid.

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

Subpart A—[Reserved]

Subpart B—Definitions

§ 400.200 General definitions.

In this chapter, unless the context indicates otherwise—

"Act" means the Social Security Act, and titles referred to are titles of that Act.

"Administrator" means the Administrator, Health Care Financing Administration.

"CFR" stands for Code of Federal Regulations.

"Department" means the Department of Health and Human Services (HHS), formerly the Department of Health, Education, and Welfare.

"ESRD" stands for end-stage renal disease.

"FR" stands for *Federal Register.*

"HCFA" stands for Health Care Financing Administration.

"HHS" stands for the Department of Health and Human Services.

"HHA" stands for home health agency.

"HMO" stands for health maintenance organization.

"ICF" stands for intermediate care facility.

"Medicaid" means medical assistance provided under a State plan approved under title XIX of the Act.

"Medicare" means the health insurance program for the aged and disabled under title XVIII of the Act.

"OASDI" stands for the Old Age, Survivors, and Disability Insurance program under title II of the Act.

"PSRO" stands for Professional Standards Review Organization.

"Regional Administrator" means a Regional Administrator of HCFA.

"Regional Office" means one of the regional offices of HCFA.

"RHC" stands for rural health clinic.

"Secretary" means the Secretary of Health and Human Services.

"SNF" stands for skilled nursing facility.

"Social security benefits" means monthly cash benefits payable under section 202 or 223 of the Act.

"SSA" stands for Social Security Administration.

"United States" means the fifty States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

"U.S.C." stands for United States Code.

§ 400.202 Definitions specific to Medicare.

As used in connection with the Medicare program, unless the context indicates otherwise—

"Beneficiary" means a person who is entitled to Medicare benefits.

"Carrier" means an entity that has a contract with HCFA to determine and make Medicare payments for Part B benefits payable on a charge basis and to perform other related functions. The term includes HCFA's Office of Direct Reimbursement, which performs carrier functions for certain facilities.

"Entitled" means that an individual meets all the requirements for Medicare benefits.

"Hospital insurance benefits" means payments on behalf of, and in rare circumstances directly to, an entitled individual for services that are covered under Part A of title XVIII of the Act.

"Intermediary" means an entity that has a contract with HCFA to determine and make Medicare payments for Part A of Part B benefits payable on a cost basis and to perform other related functions. The term includes HCFA's Office of Direct Reimbursement, which performs intermediary functions for certain providers.

"Medicare Part A" means the hospital insurance program authorized under Part A of title XVIII of the Act.

"Medicare Part B" means the supplementary medical insurance program authorized under Part B of title XVIII of the Act.

"Provider" means a hospital, a skilled nursing facility, a comprehensive outpatient rehabilitation facility, or a home health agency that has in effect an agreement to participate in Medicare, or a clinic, a rehabilitation agency, or a public health agency that has a similar agreement but only to furnish outpatient physical therapy or speech pathology services.

"Railroad retirement benefits" means monthly benefits payable to individuals under the Railroad Retirement Act of 1974 (45 U.S.C. beginning at section 231).

"Services" means medical care or services and items, such as medical diagnosis and treatment, drugs and biologicals, supplies, appliances, and equipment, medical social services, and use of hospital or SNF facilities.

"Supplementary medical insurance benefits" means payment to or on behalf of an entitled individual for services covered under Part B of title XVIII of the Act.

"Supplier" means a physician or other practitioner, or an entity other than a provider, that furnishes health care services under Medicare.

§ 400.203 Definitions specific to Medicaid.

As used in connection with the Medicaid program, unless the context indicates otherwise—

"Applicant" means an individual whose written application for Medicaid has been submitted to the agency determining Medicaid eligibility, but has not received final action. This includes an individual (who need not be alive at the time of application) whose application is submitted through a representative or a person acting responsibly for the individual.

"Federal financial participation" (FFP) means the Federal Government's share of a State's expenditures under the Medicaid program.

"FMAP" stands for the Federal medical assistance percentage, which is used to calculate the amount of Federal share of State expenditures for services.

"Medicaid agency" or *"agency"* means the single State agency administering or supervising the administration of a State Medicaid plan.

"Provider" means any individual or entity furnishing Medicaid services under a provider agreement with the Medicaid agency.

"Recipient" means an individual who has been determined eligible for Medicaid.

"Services" means the types of medical assistance specified in sections 1905(a)(1) through (18) of the Act.

"State" means the several States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and the Northern Mariana Islands.

"State plan" or *"the plan"* means a comprehensive written commitment by a Medicaid agency, submitted under section 1902(a) of the Act, to administer or supervise the administration of a Medicaid program in accordance with Federal requirements.

PART 405—FEDERAL HEALTH INSURANCE FOR THE AGED AND DISABLED

C. Part 405 is amended as set forth below:

Subpart A—Hospital Insurance Benefits

1. Subpart A is amended as follows:

a. The subpart title and the authority statement are revised, a new § 405.100 is added, and §§ 405.101 through 405.133, 405.151, 405.161, 405.180, and 405.181 are removed.

Subpart A—Hospital Insurance Benefits

Sec.
405.100 Scope.
* * * * *

Authority: Secs. 1102, 1814, 1815, 1861 and 1871 of the Social Security Act (42 U.S.C. 1302, 1395f, 1395g, 1395x, and 1395hh).

b. A new § 405.100 is added to read as follows:

§ 405.100 Scope.

This subpart deals only with conditions and procedures for payment of hospital insurance benefits (Parts A of Medicare). Provisions dealing with eligibility and entitlements are set forth in Part 408 of this chapter. Provisions dealing with the scope of the benefits are set forth in Part 409 of this chapter.

c. The content of §§ 405.101–405.133, 405.151, 405.181, 405.180, and 405.181 is revised and redesignated under new Parts 408 and 409.

Subpart B—Supplementary Medical Insurance Benefits; Enrollment, Coverage, Exclusion, and Payment

2. Subpart B is amended as set forth below:

a. The authority statement is revised to read as follows:

Authority: Secs. 1102, 1831–1843, 1861, 1862, 1866, and 1871 of the Social Security Act; 42 U.S.C. 1302, 1395j-1395v, 1395x, 1395y, 1395cc, and 1395hh.

b. Section 405.210 is amended by revising paragraph (b) to read as follows:

§ 405.210 Individual enrollment: enrollment procedures.

* * * * *

(b) *Automatic enrollment.* Any individual who is eligible to enroll in the supplementary medical insurance plan by reason of entitlement to hospital insurance and who is residing in the United States, exclusive of Puerto Rico, shall, unless he timely declines such insurance in accordance with paragraph (c) of this section, be deemed to have

enrolled in the supplementary medical insurance plan as follows:

(1) He will be deemed to have enrolled for supplementary medical insurance in the third month of his initial enrollment period if:

(i) He was entitled to monthly cash benefits under section 202 of the Act on the first day of his initial enrollment period;

(ii) He becomes entitled to monthly benefits under section 202, by filing application and meeting all other requirements during the first 33 months of that period;

(iii) He is eligible for monthly social security cash benefits under section 202 of the Act and has filed an application for hospital insurance during the first 3 months of that period (effective as specified in § 408.10 of this chapter); or

(iv) He is entitled to hospital insurance based on entitlement to social security disability benefits (see § 408.12 of this chapter), end-stage renal disease (see § 408.13 of this chapter).

* * * * *

Subpart T—Health Maintenance Organizations

3. Subpart T is amended as set forth below:

a. The authority statement is revised to read as follows:

Authority: Secs. 1102, 1871, and 1876 of the Social Security Act (42 U.S.C. 1302, 1395hh, and 1395mm).

§ 405.2020 [Amended]

b. Section 405.2020 is amended by removing the word "consecutive" in paragraphs (d)(1)(i)(*c*), and (d)(2)(i).

c. A new Part 408 is added to read as follows:

PART 408—MEDICARE ELIGIBILITY AND ENTITLEMENT

Subpart A—Hospital Insurance

General Provisions

Sec.

Hospital Insurance Without Premiums

Premium Hospital Insurance

Sec.

Special Circumstances That Affect Entitlement

Authority: Secs. 202 (t) and (u), 226, 226A, 1102, 1811 and 1818 of the Social Security Act (42 U.S.C. 402 (t) and (u), 426, 426–1, 1302, 1395c, 1395i–2; Section 103 of Pub. L. 89–97 (42 U.S.C. 426a)).

Subpart A—Hospital Insurance

General Provisions

§ 408.1 Statutory basis.

Sections 226, 226A, and 1818 of the Social Security Act and section 103 of Pub. L. 89–97 establish the conditions for entitlement to hospital insurance benefits. Sections 202 (t) and (u) of the Act specify limitations that apply to certain aliens and to persons convicted of certain offenses.

§ 408.2 Scope.

This subpart specifies the conditions of eligibility for hospital insurance and sets forth certain specific conditions that affect entitlement to benefits. Hospital insurance is authorized under Part A of Title XVIII and is also referred to as Medicare Part A. It includes inpatient hospital care, posthospital skilled nursing facility care, and posthospital home health services.

§ 408.3 Definitions.

"First month of eligibility" means the first month in which an individual meets all the requirements for entitlement to hospital insurance except application or enrollment if that is required.

"First month of entitlement" means the first month for which the individual meets all the requirements for entitlement to Part A benefits.

"Insured individual" means an individual who has the number of quarters of coverage required for monthly social security benefits.

"Quarter of coverage" means a calendar quarter that is counted toward the number of covered quarters required to make the individual eligible for monthly social security benefits. A quarter is counted if during that quarter (or that calendar year) the individual earned a required minimum amount of money. (For details, see 20 CFR Part 404, Subpart B.)

§ 408.5 Bases of eligibility and entitlement.

(a) *Hospital insurance without premiums.* Hospital insurance is available to most individuals without payment of a premium if they:

(1) Are age 65 or over, or

(2) Have received social security or railroad retirement disability benefits for 25 months; or

(3) Have end-stage renal disease. Sections 408.10 through 408.13 explain the requirements such individuals must meet to obtain hospital insurance without premiums.

(b) *Premium hospital insurance*—Many individuals who are age 65 or over, but do not meet the requirements set forth in §§ 408.10 through 408.13, may obtain the benefits by paying a premium. Section 408.20 of this part explains the requirements individuals must meet to obtain premium hospital insurance.

§ 408.6 Application or enrollment for hospital insurance.

(a) *Basic provision.* In most cases, eligibility for Medicare Part A is a result of entitlement to monthly social security or railroad retirement cash benefits or eligibility for monthly social security cash benefits. This section specifies the individuals who need not file an application to become entitled to hospital insurance, those who must file an application, and those who must enroll.

(b) *Individuals who need not file an application for hospital insurance.* An individual who is already entitled to monthly social security or railroad retirement benefits when he or she attains age 65 or who establishes entitlement to those benefits after age 65 need not file a separate application to become entitled to hospital insurance. (See 20 CFR Part 404, Subpart D for eligibility requirements for social security cash benefits, and Subpart G for requirements for filing applications for cash benefits.)

(c) *Individuals who must file an application for hospital insurance.* An individual must file an application for hospital insurance if he or she seeks entitlement to hospital insurance on the basis of—

(1) The transitional provisions set forth in § 408.11;

(2) Deemed entitlement to disabled widow's or widower's benefit under certain circumstances as provided in § 408.12;

(3) A diagnosis of end-stage renal disease, as specified in § 408.13; or

(4) Effective January 1, 1981, eligibility for social security cash benefits, as specified in § 408.10(a)(3), if the individual has attained age 65 without applying for those benefits.

(d) *When application is deemed to be filed.* (1) An application based on the transitional provisions or on ESRD is deemed to be filed in the first month of eligibility if it is filed not more than 3 months before the first month, and is retroactive to that month if filed within 12 months after the first month. An application filed more than 12 months after the first month of eligibility is retroactive to the 12th month before the month it is filed.

(2) An application for deemed entitlement to disabled widow's or widower's benefits, that if filed before the first month in which the individual meets all conditions of entitlement for this benefit, will be deemed a valid application if those conditions are met before an initial determination, reconsideration, or hearing decision is made on the application. If the conditions are met after the date of any hearing decision, a new application will have to be filed. An application validly filed within 12 months after the first month of eligibility is retroactive to that first month. If filed more than 12 months after that first month, it is retroactive to the 12th month before the month of filing.

(3) Effective June 8, 1980, an application based on eligibility for social security benefits at or after age 65, that is filed before the first month in which the individual meets all eligibility conditions for this benefit, will be deemed a valid application if those conditions are met before an initial determination, reconsideration, or hearing decision is made on the application. If the conditions are met after the date of any hearing decision, a new application will have to be filed.

(4) Effective March 1, 1981, an application validly filed within 6 months after the first month of eligibility is retroactive to that first month. If filed more than 6 months after that first month, it is retroactive to the 6th month before the month of filing.

(e) *Individuals who must enroll for hospital insurance.* An individual who must pay a monthly premium for hospital insurance must enroll in accordance with the procedures set forth in § 408.21.

Hospital Insurance Without Premiums

§ 408.10 Individual age 65 or over who is entitled to social security or railroad retirement benefits, or who is eligible for social security benefits.

(a) *Requirements.* An individual is entitled to hospital insurance benefits under Section 226 of the Act if he or she has attained aged 65 and is:

(1) Entitled to monthly social security benefits under section 202 of the Social Security Act;

(2) A qualified railroad retirement beneficiary who has been certified as such to the Social Security Administration by the Railroad Retirement Board in accordance with section 7(d) of the Railroad Retirement Act of 1974; or

(3) Effective January 1, 1981, eligible for monthly social security benefits under section 202 of the Act and has filed an application for hospital insurance.

(b) Beginning and end of entitlement.

(1) Entitlement begins with the first day of the first month in which the individual meets the requirements of paragraph (4) of this section.

(2) Entitlement continues until the individual dies or no longer meets the requirements of paragraph (a) of this section. An individual is not entitled to railroad retirement benefits and is neither entitled to, nor eligible for, monthly social security benefits in the month in which he or she dies. However, an individual who meets all other requirements for hospital insurance entitlement is entitled to hospital insurance in the month in which he or she dies if he or she—

(i) Would have been entitled to monthly railroad retirement benefits or social security benefits in that month if he or she had not died; or

(ii) Has filed an application for hospital insurance and would have been eligible for monthly social security benefits in that month if he or she had not died.

§ 408.11 Individual age 65 or over who is not eligible for social security or railroad retirement benefits.

(a) *Basis.* Section 103 of the law that established the Medicare program in 1965 (Pub. L. 89-97) provided for eligibility for certain individuals who were age 65 or would soon attain age 65 but would not be able to qualify for social security or railroad retirement benefits.

(b) *Requirements.* Unless he or she is excluded under paragraph (c) of this section, an individual age 65 or over who does not meet the requirements of § 408.10 (and who would not meet those requirements if he or she filed an application), is entitled to Medicare Part A benefits if he or she meets the following requirements:

(1) *Age and quarters of coverage.*

(i) He or she attained age 65 before 1968; or

(ii) If he or she attained age 65 in 1968 or later, he or she must have at least 3 quarters of coverage for each year that elapsed after 1968 and before the year in which he or she attained age 65. (The quarters of coverage may have been acquired at any time, not necessarily during the elapsed years.)

(2) *Residence and citizenship.* He or she is a resident of the United States and—

(i) A citizen of the United States; or

(ii) An alien lawfully admitted for permanent residence who has continuously resided in the United States for 5 years immediately preceding the first month in which he or she meets all other requirements for entitlement to hospital insurance.

(3) *Application.* He or she has filed an application for Medicare Part A no earlier than the 3 months before the first month of eligibility.

(c) *Bases for exclusion.* An individual who meets the requirements of paragraph (b) of this section is excluded from Medicare Part A if he or she—

(1) Has been convicted of spying, sabotage, or treason, sedition, and subversive action under chapter 37, 105, or 115 of title 18 of the United States Code;

(2) Has been convicted of conspiracy to establish a dictatorship under section 4 of the Internal Security Act of 1950;

(3) On February 16, 1965, was or could have been covered under the Federal Employees Health Benefits Act (FEHBA) of 1959; or

(4) In his or her first month of eligibility;

(i) Is covered by an enrollment under the FEHBA; or

(ii) Could have been covered by an enrollment under that Act if he or she (or any other person who could provide him or her with coverage) was a Federal employee at any time after February 15, 1965, and had enrolled and retained coverage under that Act.

(d) *End of exclusion.* An individual excluded under paragraph (c)(3) or (4) of this section can become entitled beginning with the first month in which he or she loses the right to FEHBA coverage solely because he or she or the other person leaves Federal employment.

(e) *Beginning and end of entitlement.*

(1) Entitlement begins—

(i) In the first month of eligibility if the application is filed no later than 12 months after the first month of eligibility;

(ii) In the 12th month before the month of application if the application is filed more than 12 months after the first month of eligibility.

(2) Entitlement continues until death or until the month before the month in which the individual becomes entitled under § 408.10.

§ 408.12 Individual under age 65, who is entitled to social security or railroad retirement disability benefits

(a) *Basic requirements.*

An individual under age 65 is entitled to hospital insurance benefits if, for 25 months, he or she has been—

(1) Entitled or deemed entitled to social security disability benefits as an insured individual, child, widow, or widower who is "under a disability" or

(2) A disabled qualified beneficiary certified under Section 7(d) of the Railroad Retirement Act.

(b) *Previous periods of disability benefit entitlement.*[1] Months of a previous period of entitlement or deemed entitlement to disability benefits will count toward the 25-month requirement if—

(1) Entitlement was an insured individual or a disabled qualified railroad retirement beneficiary, and the previous period ended within the 60 months preceding the month in which the current disability began; or

(2) Entitlement was as a disabled child, widow, or widower, and the previous period ended within the 84 months preceding the month in which the current disability began.

(c) *Deemed entitlement to disabled widow's or widower's monthly benefits.*

(1) *Purpose.* The provisions of paragraphs(c)(2), (3), and (4) of this section are intended to enable individuals—

(i) To meet the 25-month requirement of paragraph (a) of this section; or

(ii) To retain hospital insurance entitlement when they are no longer entitled to monthly disability benefits.

(2) *Deemed entitlement for certain individuals entitled to old-age insurance benefits.*

An individual who becomes entitled to monthly old-age insurance benefits before age 65, is, by law, precluded from establishing or retaining entitlement to disabled widow's or widower's monthly benefits. However, for purposes of meeting the 25-month requirement, a widow or widower who meets all other requirements for disability benefits and is excluded solely because of entitlement to old-age insurance benefits, shall be deemed to be (or to continue to be) entitled to disability benefits. A widow or widower who is not entitled to disability benefits for the month before attaining age 60 must file two applications, one for old-age insurance benefits and one for hospital insurance.

(3) *Deemed entitlement for certain individuals entitled to mother's benefits.* An individual entitled to mother's insurance benefits under section 202(g) of the Social Security Act cannot at the same time be entitled to disabled widow's benefits. However, if she applies for hospital insurance, she will be deemed to be entitled to disabled widow's monthly benefits in the first month (of the 12 months before application) in which she would have been entitled to those benefits if she had filed an application for them.

(4) *Deemed retroactive entitlement for certain disabled widows and widowers.* In some cases, disabled widows or widowers cannot become entitled to monthly cash benefits before the month in which they file application. However, for purposes of meeting the 25-month requirement, disability benefit entitlement will be deemed to have begun with the earliest month (of the 12 months before the application for cash benefits) in which the individual met all the requirements except the filing of an application. (This provision is effective for applications filed on or after January 1, 1978.)

(d) *When entitlement begins and ends.*

(1) Entitlement to hospital insurance begins with the 25th month of an individual's entitlement or deemed entitlement to disability benefits. Although an individual is not entitled to disability benefits for the month in which he or she dies, for purposes of this paragraph the individual will be deemed to be entitled for the month of death.

(2) Except as provided in paragraph (e) of this section, entitlement to hospital insurance ends with the earliest of the following:

(i) The last day of the last month in which he or she was entitled or deemed entitled to disability benefits or was qualified as a disabled railroad retirement beneficiary, if he or she was notified of the termination of entitlement before that month.

(ii) The last day of the month following the month in which he or she is mailed a notice that his or her entitlement or deemed entitlement to disability benefits, or his or her status as a qualified disabled railroad retirement beneficiary, has ended.

(iii) The last day of the month before the month he or she attains age 65. (An individual who is entitled to social security or railroad retirement cash benefits for the month of attainment of age 65 is automatically entitled to hospital insurance under § 408.10.)

(iv) The day of death.

(e) *Continuation of Medicare entitlement when disability benefit entitlement ends because of substantial gainful activity.* (1) *Definition.* As used in this paragraph (e), *"trial work period"* means the 9-month period provided under title II of the Act, during which the individual may test his or her ability to work and still receive disability cash benefits.

(2) *Duration of continued Medicare entitlement.* Effective December 1, 1980, if an individual's entitlement to disability benefits or status as a qualified disabled railroad retirement beneficiary ends because he or she engaged in, or demonstrated the ability to engage in, substantial gainful activity after the 15 months following the end of the trial work period, Medicare entitlement continues until the earlier of the following:

(i) The last day of the 24th month after the month in which the individual's entitlement to disability benefits or status as a qualified railroad retirement beneficiary ends if—

(A) The physical or mental impairment, on which that entitlement or status was based, continues through the 24-month period; and

(B) The individual remains otherwise eligible for disability benefits throughout this period.

(ii) The last day of the month following the month in which notice is mailed to the individual indicating that he or she is no longer entitled to hospital insurance because of an event or circumstance (e.g., the impairment has ceased, or the disabled widow has remarried) that would terminate disability benefit entitlement if it had not already been terminated because of substantial gainful activity.

§ 408.13 Individual who has end-stage renal disease.

(a) *Statutory basis and applicability.* This section explains the conditions of entitlement to hospital insurance benefits on the basis of end-stage renal disease, and specifies the beginning and end of the period of entitlement. It implements section 226A of the Social Security Act.

[1] Before December 1, 1980, the law required that the 25 months of disability entitlement be consecutive. The Social Security Disability Amendments of 1980 deleted that requirement.

(b) *Definitions.* As used in this section:

"End-stage renal disease" (ESRD) means that stage of kidney impairment that appears irreversible and permanent and requires a regular course of dialysis or kidney transplantation to maintain life.

"Child" or "spouse" means a child or spouse whose relationship to the parent or spouse meets the relationship requirements for entitlement to child's monthly social security benefits or to wife's, husband's, widow's, widower's, mother's or father's monthly benefits, as set forth in 20 CFR Part 404. However, the duration of relationship requirements apply only to divorced spouses. (See 20 CFR 404.331.)

"Dependent child" means a person who, on the first day he or she has end-stage renal disease, is unmarried and meets the dependency requirements for entitlement to child's social security benefits on the basis of a parent's earnings (see 20 CFR 404.350–404.365) and who—

(1) Is under age 22;

(2) Is under a disability that began before age 22; or

(3) Is under age 26, is receiving at least one-half support from that parent, and has continuously received at least one-half support from that parent since the day before attaining age 22.

"One-half support" means regular contributions, in cash or in kind, that equals or exceeds one-half of the child's total support.

(c) *Requirements.* An individual is entitled to hospital insurance benefits if—

(1) He or she is medically determined to have, ESRD;

(2) He or she is:

(i) Fully or currently insured under the social security program (title II of the Act) or would be fully or currently insured if his or her employment (after 1936) as defined under the Railroad Retirement Act were considered "employment" under the Social Security Act;

(ii) Entitled to monthly social security or railroad retirement benefits; or

(iii) The spouse or dependent child of a person who meets the requirements of paragraph (c)(2)(i) of (c)(2)(ii) of this section;

(3) He or she has filed an application for Medicare Part A; and

(4) He or she has satisfied the waiting period explained in paragraph (e) of this section.

(d) *Filing an application.*

(1) An individual may obtain an application form, and help in completing it, from any social security office.

(2) An application is not valid if it is filed earlier than the third month before the month in which the individual meets the conditions of paragraphs (c)(1), (c)(2), and (c)(4) of this section.

(3) If an individual who has ESRD dies before he or she has filed an application, or is unable to file because of physical or mental condition, a relative or other person responsible for his or her affairs may file in his or her behalf. If a responsible person is not available, the hospital or dialysis facility that furnished treatment may file the application.

(e) *Beginning of entitlement.*

(1) *Basic limitations.* Entitlement can begin no earlier than the first month in which the individual meets the conditions specified in paragraph (c) of this section, or the 12th month before the month of application, whichever is later.

(2) *Waiting period.* Entitlement begins on the first day of the third month after the month in which the individual initiates a regular course of renal dialysis, if the course is maintained throughout the waiting period, unless entitlement would begin earlier under paragraph (e) (3) or (4) of this section. This means that if dialysis began in January, entitlement would begin April 1.

(3) *Exceptions: Early kidney transplant.* If the individual receives a transplant, entitlement begins with the first day of the month in which the transplant was performed. However, if the individual is admitted as an inpatient to a hospital that is an approved renal transplantation center or renal dialysis center (see § 405.2102) for procedures preliminary to transplant surgery, entitlement begins—

(i) On the first day of the month in which he or she initially enters the hospital, if the transplant is performed in that month or in either of the next 2 months; or

(ii) On the first day of the second month before the month of kidney transplantation, if the transplant is delayed more than 2 months after the month of initial hospital stay.

For example, if an individual enters the hospital in January, and the transplant is performed in January, February, or March, entitlement would begin January 1. However, if the transplant is performed in April, entitlement would begin February 1.

(4) *Exceptions: Self-dialysis training.* Entitlement begins on the first day of the month in which a regular course of renal dialysis began if:

(i) Before the end of the waiting period, the individual participates in a self-dialysis training program offered by a participating Medicare facility that is approved to provide such training;

(ii) The patient's physician has certified that it is reasonable to expect the individual will complete the training program and will self-dialyze on a regular basis; and

(iii) The regular course of dialysis is maintained throughout the time that would otherwise be the waiting period (unless it is terminated earlier because the individual dies).

(f) *End of entitlement.* Entitlement ends with:

(1) The end of the 12th month after the month in which a course of dialysis ends, unless the individual receives a kidney transplant during that period or begins another regular course of dialysis; or

(2) The end of the 36th month after the month in which the individual has received a kidney transplant, unless the individual receives another kidney transplant or begins a regular course of dialysis during that period.

(g) *Resumption of entitlement.* An individual who initiates dialysis more than 36 months after the month of a kidney transplant or resumes dialysis more than 12 months after the month a previous course of dialysis ended must submit a new application but need not serve a waiting period. If he or she is otherwise entitled under the conditions specified in paragraph (c) of this section, and files an application, entitlement begins with the month in which dialysis is initiated or resumed, subject to the limitations of paragraph (e)(1) of this section.

Premium Hospital Insurance

§ 408.20 Basic requirements.

(a) *General provisions.* Hospital insurance benefits are available to most individuals age 65 or over who do not qualify for those benefits under §§ 408.10 through 408.13 of this subpart and are willing to pay a monthly premium. This is called premium hospital insurance.

(b) *Eligibility to enroll for premium hospital insurance.*

An individual is eligible to enroll for Medicare Part A if he or she.

(1) Has attained age 65;

(2) Is a resident of the United States and is either—

(i) A citizen of the United States; or

(ii) An alien lawfully admitted for permanent residence who has resided in the United States continuously for the 5-year period immediately preceding the month in which he or she meets all other requirements;

(3) Is not eligible for Part A benefits under §§ 408.10—408.13; and

(4) Is entitled to supplementary medical insurance (Part B of Medicare) or is eligible and has enrolled for it during an enrollment period.

§ 408.21 Enrollment and entitlement.

(a) *Basic provision.* An individual who meets the requirements of § 408.20(b) may enroll for premium hospital insurance only during his or her "initial enrollment period" or a "general enrollment period," as set forth in paragraphs (b) through (d) of this section.

(b) *Initial enrollment period.* (1) *Duration.* The initial enrollment period extends for 7 months, from the third month before the month the individual first meets the requirements of § 408.20 (b)(1) through (b)(3) through the third month after that first month of eligibility.

(2) *Effect of month of enrollment on entitlement.* (i) If the individual enrolls during the 3 months before the first month of eligibility, entitlement begins with the first month of eligibility.

(ii) If the individual enrolls in the first month of eligibility, entitlement begins with the following month.

(iii) If the individual enrolls during the month after the first month of eligibility, entitlement begins with the second month after the month of enrollment.

(iv) If the individual enrolls in either of the last 2 months of the enrollment period, entitlement begins with the third month after the month of enrollment.

(c) *General enrollment period.* (1) Except as specified in paragraph (c)(4) of this section, the general enrollment period extends from January 1 to March 31 of each calendar year.

(2) General enrollment periods are for individuals who fail to enroll during their initial enrollment periods or whose previous period of entitlements has terminated.

(3) If the individual enrolls or reenrolls during a general enrollment period, his or her entitlement begins on July 1 of the calendar year.

(4) During the period April 1 through September 30, 1981, the general enrollment period was any time after the end of the individual's initial enrollment period. Any eligible individual whose initial enrollment period has ended, or whose previous period of entitlement had terminated, could enroll or reenroll during that 6-month period.

(d) *"Deemed" initial enrollment period.* (1) If an individual fails to enroll during the initial enrollment period because of reliance on incorrect documentary information which led him or her to believe that he or she was not yet age 65, an initial enrollment period may be established for him or her as though he or she had attained age 65 on the date indicated by the incorrect documentary information.

(2) The deemed initial enrollment period will be used to determine the individual's premium and right to enroll in a general enrollment period if such use is advantageous to the individual.

§ 408.22 Monthly premiums.

(a) *General provisions.* (1) For months before July 1974, the monthly premium was $33.

(2) For months after June 1974, premiums have been determined for each 12-month period beginning July 1, and published in the **Federal Register** during the last quarter of the preceding calendar year.

(b) *Monthly premiums: Determination of dollar amount.* (1) The dollar amount is determined by multiplying $33 by the ratio of next year's inpatient deductible to $76, which was the inpatient deductible determined for 1973. (Because of cost controls, the deductible actually charged for that year was $72.)

(2) The amount determined by the mathematical formula is rounded to the nearest multiple of $1. (Fifty cents is rounded to the next higher dollar.)

(c) *Monthly premiums. Increase for late enrollment and for reenrollment.* For an individual who enrolls after the close of the initial enrollment period or reenrolls, the amount of the monthly premium, as determined under paragraph (b) of this section, is increased by 10% for each full 12 months in the periods described in §§ 408.23 and 408.24.

(d) *Collection of monthly premiums.* (1) HCFA will bill the enrollee on a monthly basis and include an addressed return envelope with the bill.

(2) The enrollee must pay by check or money order that is payable to "HCFA Medicare Insurance," and shows his or her name and the claim number that appears on his or her Medicare card. He or she must return the bill with the check or money order.

§ 408.23 Determination of months to be counted for premium increase: Enrollment.

(a) *Enrollment before April 1, 1981 or after September 30, 1981.* The months to be counted for premium increase are the months from the end of the initial enrollment period through the end of the general enrollment period in which the individual enrolls, excluding any months before September 1973.

(b) *Enrollment during the period April 1 through September 30, 1981.* The months to be counted for premium increase are the months from the end of the initial enrollment period through the month in which the individual enrolled, excluding any months before September 1973.

(c) *Examples.* (1) John F's initial enrollment period ended July 1979 but he did not enroll until January 1980. The months to be counted are August 1979 through March 1980. Since only 8 months elapsed, there is no premium increase.

(2) Mary T's initial enrollment period ended in April 1980 but she did not enroll until May 1981. The months to be counted are May 1980 through May 1981. Since 13 months has elapsed, the premium would be increased by 10 percent.

§ 408.24 Determination of months to be counted for premium increase: Reenrollment.

(a) *First reenrollment before April 1, 1981 or after September 30, 1981.* The months to be counted for premium increase are:

(1) The months specified in § 408.23(a) or (b); plus

(2) The months from the end of the first period of entitlement through the end of the general enrollement period in which the individual reenrolled.

(b) *First reenrollment during the period April 1, 1981* through September 30, 1981. The months to be counted for premium increase are—

(1) The months specified in § 408.23(a); plus

(2) The months from the end of the first period of entitlement through the month in which the individual reenrolled.

(c) *Subsequent reenrollment during the period April 1, 1981 through September 30, 1981.* The months to be counted for premium increase are—

(1) The months specified in paragraph (a) of this section; plus

(2) The months from April 1981 through the month in which the individual reenrolled for the second time. (Since only one reenrollment was permitted before April 1981, any months from the end of the individual's first enrollment period of entitlement through March 1981 are not counted.)

(d) *Subsequent reenrollment after September 30, 1981.* The months to be counted for premium increase are—

(1) The months specified in paragraph (a) or (b) of this section, for the first and second periods of coverage; plus

(2) The months from the end of each subsequent period of entitlement through the end of the general enrollment period in which the individual reenrolled, excluding any months before April 1981.

(e) *Example.* Peter M enrolled during his initial enrollment period, terminated his first coverage period in August 1979 and reenrolled for the first time in January 1980. The 7 months to be counted (September 1979 through March, 1980) were not enough to require any increase in the premium. Peter terminated his second period of coverage in February 1981 and reenrolled for the second time in July 1981. Since the 4 months (April through July 1981), when added to the previous 7 months, bring the total to only 11 months, no premium increase is required.

§ 408.25 Termination of entitlement.

Any of the following actions or events will terminate entitlement:

(a) *Filing of request for termination.* The beneficiary may at any time give HCFA or the Social Security Administration written notice that he or she no longer wishes to participate in the premium hospital insurance program.

(1) If he or she files the notice before entitlement begins, he or she will be deemed not to have enrolled.

(2) If he or she files the notice after entitlement begins, that entitlement will end at the close of the month following the month in which he or she filed the notice.

(b) *Eligibility for hospital insurance without premiums.* (1) If an individual meets the eligibility requirements for hospital insurance specified in § 408.10 or § 408.11, entitlement to premium hospital insurance ends with the month before the month in which he or she meets those requirements.

(2) If an individual meets the requirements of § 408.10 or § 408.11, he or she will be deemed to have filed the required application for hospital insurance benefits in his or her first month of eligibility under that section.

(c) *Termination of supplementary medical insurance.* If an individual's entitlement to supplementary medical insurance ends for any reason, entitlement to premium hospital insurance will end on the same date.

(d) *Nonpayment of premium.* (1) If an individual fails to pay the premium bill, entitlement will end on the last day of the third month after the billing month.

(2) HCFA may reinstate entitlement if the individual shows good cause for failure to pay on time, and pays all overdue premiums within 3 calendar months after the date specified in paragraph (d)(1) of this section.

(e) *Death.* Entitlement ends with the day of death. (A premium is due for the month of death.)

§ 408.26 Prejudice to enrollment rights because of Federal Government error.

(a) If an individual's enrollment or nonenrollment for premium hospital insurance is unintentional, inadvertent, or erroneous because of the error, misrepresentation, or inaction of a Federal employee, or any person authorized by the Federal Government to act on its behalf, the Social Security Administration or HCFA may take whatever action it determines is necessary to provide appropriate relief.

(b) The action may include—

(1) Designation of a special initial or general enrollment period;

(2) Designation of an entitlement period;

(3) Adjustment of premiums;

(4) Any combination of the actions specified in paragraph (b) (1) through (3) of this section; or

(5) Any other remedial action which may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction.

Special Circumstances That Affect Entitlement

§ 408.30 Nonpayment of benefits on behalf of certain aliens.

(a) Hospital insurance benefit payments may not be made for services furnished to an alien in any month in which his or her monthly social security benefits are suspended (or would be suspended if he or she were entitled to those benefits) because the alien remains outside the United States for more than 6 months.

(b) Benefits will be payable beginning with services furnished in the first full calendar month the alien is back in the United States.

§ 408.31 Conviction of certain offenses.

(a) *Penalty that affects entitlement.*

(1) If an individual is convicted of any of the crimes listed in § 408.11(c) (1) and (2), the court may impose, in addition to all other penalties, a penalty that affects entitlement to hospital insurance, beginning with the month of conviction.

(2) The additional penalty is that the individual's income (or the income of the insured individual on whose earnings record he or she became or seeks to become entitled) for the year of conviction and any previous year may not be counted in determining the insured status necessary for entitlement to hospital insurance.

(b) *Effect of pardon.* If the President of the United States pardons the convicted individual, that individual regains (or may again seek) entitlement effective with the month following the month in which the pardon is granted.

E. A new Part 409 is added, to read as follows:

PART 409—MEDICARE BENEFITS, LIMITATIONS, AND EXCLUSIONS

Subpart A—Hospital Insurance

General Provisions

Sec.

Inpatient Hospital Services

Posthospital SNF Care

Requirements for Coverage of Posthospital SNF Care

Home Health Services

Scope of Benefits

Sec.

Deductibles and Coinsurance

Authority: Secs. 1102, 1812, 1813, 1814, 1861, 1866, 1871, 1881, and 1883 of the Social Security Act (42 U.S.C. 1302, 1395d, 1395e, 1395f, 1395x 1395cc, 1395hh, 1395rr, and 1395tt).

Subpart A—Hospital Insurance

General Provisions

§ 409.1 Statutory basis.

Sections 1812 and 1813 of the Social Security Act establish the scope of benefits of the hospital insurance program under Medicare Part A and set forth the deductible and coinsurance requirements.

§ 409.2 Scope.

This subpart describes the benefits available under Medicare Part A and sets forth the limitations on those benefits, including certain amounts of payment for which beneficiaries are responsible.

§ 409.3 Definitions.

As used in this subpart, unless the context indicates otherwise—

"Arrangements" means arrangements which provide that Medicare payment made to the provider that arranged for the services discharges the liability of the beneficiary or any other person to pay for those services.

"Covered" refers to services for which the law and the regulations authorize Medicare payment.

"Participating" refers to a hospital or other facility that meets the conditions of participation and has in effect a Medicare provider agreement.

"Qualified hospital" means a facility that—

(a) Is primarily engaged in providing, by or under the supervision of doctors of medicine or osteopathy, inpatient services for the diagnosis, treatment, and care or rehabilitation of persons who are sick, injured, or disabled;

(b) Is not primarily engaged in providing skilled nursing care and related services for inpatients who require medical or nursing care;

(c) Provides 24-hour nursing service in accordance with Sec. 1861(e)(5) of the Act;

(d) If it is a U.S. hospital, is licensed, or approved as meeting the standards for licensing, by the State or local licensing agency; and

(e) If it is a foreign hospital, is licensed, or approved as meeting the standard for licensing, by the appropriate Canadian or Mexican licensing agency, and for purposes of furnishing non-emergency services to U.S. residents, is accredited by the Joint Commission on Accreditation of Hospitals (JCAH), or by a Canadian or Mexican program under standards that HCFA finds to be equivalent to those of the JCAH.

§ 409.5 General description of benefits.

Hospital insurance (Part A of Medicare) helps pay for inpatient hospital services and posthospital SNF care. It also pays for home health services. There are limitations on the number of days of care that Medicare can pay for and there are deductible and coinsurance amounts for which the beneficiary is responsible. For each type of service, certain conditions must be met, as specified in the pertinent sections of this subpart.

The special conditions for inpatient hospital services furnished by a qualified U.S., Canadian, or Mexican hospital are set forth in Part 405, Subpart A of this chapter.

Inpatient Hospital Services

§ 409.10 Included services.

(a) Subject to the conditions, limitations, and exceptions in paragraph (b) of this section and in §§ 409.11 through 409.18, the term "inpatient hospital services" means the following services furnished to an inpatient of a participating hospital or, in the case of emergency services or services in foreign hospitals, to an inpatient of a qualified hospital:

(1) Bed and board;

(2) Nursing services and other related services;

(3) Use of hospital facilities;

(4) Medical social services;

(5) Drugs, biologicals, supplies, appliances, and equipment;

(6) Certain other diagnostic or therapeutic services; and

(7) Medical or surgical services provided by certain interns or residents-in-training.

(b) "Inpatient hospital services" does not include SNF-type care or intermediate care facility (ICF)-type care furnished by a hospital that has a swing-bed approval.

§ 409.11 Bed and board.

(a) *Semiprivate and ward accommodations.* Except for applicable deductible and coinsurance amounts, Medicare Part A pays in full for bed and board and semiprivate (2 to 4 beds), or ward (5 or more beds) accommodations.

(b) *Private accommodations.* (1) *Conditions for payment in full.* Except for applicable deductible and coinsurance amounts, Medicare Part A pays in full for a private room if—

(i) The patient's condition requires him or her to be isolated;

(ii) The hospital has no semiprivate or ward accommodations; or

(iii) The hospital's semiprivate and ward accommodations are fully occupied by other patients, were so occupied at the time the patient was admitted to the hospital for treatment of a condition that required immediate inpatient hospital care, and have been so occupied during the interval.

(2) *Period of payment.* In the situations specified in paragraph (b)(1) (i) and (iii) of this section, Medicare pays for a private room until the patient's condition no longer requires isolation or until semiprivate or ward accommodations are available.

(3) *Conditions for patient's liability.* The hospital may charge the patient the difference between its customary charge for the private room and its most prevalent charge for a semiprivate room if—

(i) None of the conditions of paragraph (b)(1) of this section is met; and

(ii) The private room was requested by the patient or a member of the family, who, at the time of the request, was informed what the hospital's charge would be.

§ 409.12 Nursing and related services, medical social services; use of hospital facilities.

(a) Medicare pays for nursing and related services, use of hospital facilities, and medical social services as inpatient hospital services only if those services are ordinarily furnished by the hospital for the care and treatment of inpatients.

(b) Except as specified in paragraph (c) of this section, Medicare does not pay for the services of a private duty nurse or attendant.

(c) Medicare pays for services furnished by a nurse or attendant who is a bona fide employee of the hospital during the time he or she provides the services. Medicare pays for the services

of a private duty nurse or attendant employed by the hospital only if the beneficiary's condition requires such services.

§ 409.13 Drugs and biologicals.

(a) Except as specified in paragraph (b) of this section, Medicare pays for drugs and biologicals as inpatient hospital services only if—

(1) They represent a cost to the hospital;

(2) They are ordinarily furnished by the hospital for the care and treatment of inpatients; and

(3) They are furnished to an inpatient for use in the hospital.

(b) *Exception.* Medicare pays for a limited supply of drugs for use outside the hospital if it is medically necessary to facilitate the beneficiary's departure from the hospital and required until he or she can obtain a continuing supply.

§ 409.14 Supplies, appliances, and equipment.

(a) Except as specified in paragraph (b) of this section, Medicare pays for supplies, appliances, and equipment as inpatient hospital services only if—

(1) They are ordinarily furnished by the hospital to inpatients; and

(2) They are furnished to inpatients for use in the hospital.

(b) *Exceptions.* Medicare pays for items to be used beyond the hospital stay if—

(1) The item is one that the beneficiary must continue to use after he or she leaves the hospital, for example, heart valves or a heart pacemaker, or

(2) The item is medically necessary to permit or facilitate the beneficiary's departure from the hospital and is required until the beneficiary can obtain a continuing supply. Tracheostomy or draining tubes are examples.

§ 409.15 Services furnished by an intern or a resident-in-training.

Medical or surgical services provided by an intern or a resident-in-training are included as "inpatient hospital services" if they are provided—

(a) By an intern or a resident-in-training under a teaching program approved by the Council on Medical Education of the American Medical Association, or the Bureau of Professional Education of the American Osteopathic Association;

(b) By an intern or a resident-in-training in the field of dentistry under a teaching program approved by the Council on Dental Education of the American Dental Association; or

(c) By an intern or a resident-in-training in the field of podiatry under a teaching program approved by the Council on Podiatry Education of the American Podiatry Association.

§ 409.16 Other diagnostic or therapeutic services.

Diagnostic or therapeutic services other than those provided for in §§ 409.12, 409.13, and 409.14 are considered as inpatient hospital services if—

(a) They are furnished by the hospital, or by others under arrangements made by the hospital;

(b) Billing for those services is through the hospital; and

(c) The services are of a kind ordinarily furnished to inpatients either by the hospital or under arrangements made by the hospital.

§ 409.18 Services related to kidney transplantations.

(a) *Kidney transplants.* Medicare pays for kidney transplantation surgery only if performed in a renal transplantation center approved under Subpart U of Part 405 of this chapter.

(b) *Services in connection with kidney donations.* Medicare pays for services related to the evaluation or preparation of a potential or actual donor, to the donation of the kidney, or to postoperative recovery services directly related to the kidney donation—

(1) If the kidney is intended for an individual who has ESRD and is entitled to Medicare benefits or can be expected to become so entitled within a reasonable time; and

(2) Regardless of whether the donor is entitled to Medicare.

Posthospital SNF Care

§ 409.20 Coverage of services

(a) *Included services.* Subject to the conditions and limitations set forth in paragraph (b) of this section and in §§ 409.22–409.35, "posthospital SNF care" means the following services furnished to an inpatient of a participating SNF or a hospital that has a swing-bed approval.

(1) Nursing care provided by or under the supervision of a registered professional nurse;

(2) Bed and board in connection with the furnishing of that nursing care;

(3) Physical, occupational, or speech therapy;

(4) Medical social services;

(5) Drugs, biologicals, supplies, appliances, and equipment;

(6) Certain medical services provided by an intern or resident-in-training;

(7) Certain other diagnostic or therapeutic services; and

(8) Other services that are necessary to the health of the patient and are generally provided by SNFs.

(b) *Excluded services.* (1) *Services that are not considered inpatient hospital services.* No service is included as posthospital SNF care if it would not be included as an inpatient hospital service under §§ 409.11 through 409.18.

(2) *Services not generally provided by SNFs.* Except as specifically listed in §§ 409.22 through 409.27, only those services generally provided by SNFs are considered as posthospital SNF care. For example, if an individual is furnished the use of an operating room by a SNF, that service is not included as "posthospital SNF care" because SNFs generally do not maintain operating rooms.

(c) *Terminology.* In §§ 409.22 through 409.36—

(1) The terms "SNF" and "swing-bed hospital" are used when the context applies to the particular facility.

(2) The term "facility" is used to mean both SNFs and swing-bed hospitals.

§ 409.22 Bed and board.

(a) *Semiprivate and ward accommodations.* Except for applicable deductible and coinsurance amounts Medicare Part A pays in full for semiprivate (2 to 4 beds), or ward (5 or more beds) accommodations.

(b) *Private accommodations.* (1) *Conditions for payment in full.* Except for applicable coinsurance amounts, Medicare pays in full for a private room if—

(i) The patient's condition requires him to be isolated;

(ii) The SNF has no semiprivate or ward accommodations; or

(iii) The SNF semiprivate and ward accommodations are fully occupied by other patients, were so occupied at the time the patient was admitted to the SNF for treatment of a condition that required immediate inpatient SNF care, and have been so occupied during the interval.

(2) *Period of payment.* In the situations specified in paragraph (b)(1) (i) and (iii) of this section. Medicare pays for a private room until the patient's condition no longer requires isolation or until semiprivate or ward accommodations are available.

(3) *Conditions for patient's liability.* The facility may charge the patient the difference between its customary charge for the private room furnished and its most prevalent charge for a semiprivate room if:

(i) None of the conditions of paragraph (b)(1) of this section is met and

(ii) The private room was requested by the patient or a member of the family

who, at the time of request was informed what the charge would be.

§ 409.23 Physical, occupational, and speech therapy.

Medicare pays for physical, occupational, or speech therapy is posthospital SNF care if—

(a) It is furnished by the facility or under arrangements made by the facility, and

(b) Billing for the therapy is by or through the facility.

§ 409.24 Drugs and biologicals.

(a) Except as specified in paragraph (b) of this section. Medicare pays for drugs and biologicals as posthospital SNF care only if—

(1) They represent a cost to the facility;

(2) They are ordinarily furnished by the facility for the care and treatment of inpatients; and

(3) They are furnished to an inpatient for use in the facility.

(b) *Exception.* Medicare pays for a limited supply of drugs for use outside the facility if it is medically necessary to facilitate the beneficiary's departure from the facility and required until he or she can obtain a continuing supply.

§ 409.25 Supplies, appliances, and equipment.

(a) Except as specified in paragraph (b) of this section. Medicare pays for supplies, appliances, and equipment as posthospital SNF only if—

(1) They are ordinarily furnished by the facility to inpatients; and

(2) They are furnished to inpatients for use in the facility.

(b) *Exception.* Medicare pays for items to be used after the individual leaves the facility if—

(1) The item is one that the beneficiary must continue to use after leaving, such as a leg brace; or

(2) The item is necessary to permit or facilitate the beneficiary's departure from the facility and is required until he or she can obtain a continuing supply. Sterile dressings would be an example.

§ 409.26 Services furnished by an intern or a resident-in-training.

Medicare pays for medical services furnished by an intern or a resident-in-training as posthospital SNF care if—

(a) The intern or resident is in a participating hospital with which the SNF has in effect an agreement for the transfer of patients and exchange of medical records or in a hospital that has a swing-bed approval; and

(b) The intern or resident furnishes the services under a hospital teaching program approved in accordance with the provisions of §409.15.

§ 409.27 Other diagnostic of therapeutic services.

Medicare pays for other diagnostic or therapeutic services as posthospital SNF care if provided by a participating hospital with which the SNF has in effect an agreement for the transfer of patients and exchange of clinical records, or by a hospital that has a swing-bed approval.

Requirements for Coverage of Posthospital SNF Care

§ 409.30 Basic requirements.

Posthospital SNF care, including SNF-type care furnished in a hospital that has a swing-bed approval, is covered only if the beneficiary meets the requirements of this section and only for days when he or she needs and receives care of the level described in § 409.31.

(a) *Pre-admission requirements.* The beneficiary must—

(1) Have been hospitalized in a participating or qualified hospital, for medically necessary inpatient hospital care, for at least 3 consecutive calendar days, not counting the day of discharge; and

(2) Have been discharged from the hospital in a month for which he or she was entitled to hospital insurance benefits, in accordance with Part 408 of this chapter.

(b) *Date of admission requirements.*[1]

(1) Except as specified in paragraph (b)(2) of this section, the beneficiary must be in need of posthospital SNF care, be admitted to the facility, and receive the needed care within 30 calendar days after the date of discharge from a hospital.

(2) *Exception.* A beneficiary for whom posthospital SNF care would not be medically appropriate within 30 days after discharge from the hospital may be admitted at the time it would be medically appropriate to begin an active course of treatment.

§ 409.31 Level of care requirement.

(a) *Definition.* As used in this section, "skilled nursing and skilled rehabilitation services" means services that:

(1) Are ordered by a physician;

(2) Require the skills of technical or professional personnel such as registered nurses, licensed practical (vocational) nurses, physical therapists, occupational therapists, and speech pathologists or audiologists; and

(3) Are furnished directly by, or under the supervision of, such personnel.

(b) *Specific conditions for meeting level of care requirements.*

(1) The beneficiary must require skilled nursing or skilled rehabilitation services, or both, on a daily basis.

(2) Those services must be furnished for a condition—

(i) For which the beneficiary received inpatient hospital services; or

(ii) Which arose while the beneficiary was receiving care in a SNF or swing-bed hospital for a condition for which he or she received inpatient hospital services.

(3) The daily skilled services must be ones that, as a practical matter, can only be provided in a SNF, on an inpatient basis.

§ 409.32 Criteria for skilled services and the need for skilled services.

(a) The service must be so inherently complex that it can be safely and effectively performed only by, or under the supervision of, professional or technical personnel.

(b) A condition that does not ordinarily require skilled services may require them because of special medical complications. Under those circumstances, a service that is usually nonskilled (such as those listed in § 409.33(d)) may be considered skilled because it must be performed or supervised by skilled nursing or rehabilitation personnel. For example, a plaster cast on a leg does not usually require skilled care. However, if the patient has a preexisting acute skin condition or needs traction, skilled personnel may be needed to adjust traction or watch for complications. In situations of this type, the complications, and the skilled services they require, must be documented by physicians' orders and nursing or therapy notes.

(c) The restoration potential of a patient is not the deciding factor in determining whether skilled services are needed. Even if full recovery or medical improvement is not possible, a patient may need skilled services to prevent further deterioration or preserve current capabilities. For example, a terminal cancer patient may need some of the skilled services described in § 409.33.

§ 409.33 Examples of skilled nursing and rehabilitation services.

(a) *Services that could qualify as either skilled nursing or skilled rehabilitation services (1) Overall management and evaluation of care*

[1] Before December 5, 1980, the law required that admission and receipt of care be within 14 days after discharge from the hospital and permitted admission up to 28 days after discharge if a SNF bed was not available in the geographic area in which the patient lived, or at the time it would be medically appropriate to begin an active course of treatment, if SNF care would not be medically appropriate within 14 days after discharge.

plan. The development, management, and evaluation of a patient care plan based on the physician's orders constitute skilled services when, because of the patient's physical or mental condition, those activities require the involvement of technical or professional personnel in order to meet the patient's needs, promote recovery, and ensure medical safety. This would include the management of a plan involving only a variety of personal care services when, in light of the patient's condition, the aggregate of those services requires the involvement of technical or professional personnel. For example, an aged patient with a history of diabetes mellitus and angina pectoris who is recovering from an open reduction of a fracture of the neck of the femur requires, among other services, careful skin care, appropriate oral medications, a diabetic diet, an exercise program to preserve muscle tone and body condition, and observation to detect signs of deterioration in his or her condition or complications resulting from restricted, but increasing, mobility. Although any of the required services could be performed by a properly instructed person, such a person would not have the ability to understand the relationship between the services and evaluate the ultimate effect of one service on the other. Since the nature of the patient's condition, age, and immobility create a high potential for serious complications, such an understanding is essential to ensure the patient's recovery and safety. Under these circumstances, the management of the plan of care would require the skills of a nurse even though the individual services are not skilled. Skilled planning and management activities are not always specifically identified in the patient's clinical record. Therefore, if the patient's overall condition would support a finding that recovery and safety can be assured only if the total care is planned, managed, and evaluated by technical or professional personnel, it would be appropriate to infer that skilled services are being provided.

(2) *Observation and assessment of the patient's changing condition.* Observation and assessment constitute skilled services when the skills of a technical or professional person are required to identify and evaluate the patient's need for modification of treatment for additional medical procedures until his or her condition is stabilized. For example, a patient with congestive heart failure may require continuous close observation to detect signs of decompensation, abnormal fluid balance, or adverse effects resulting from prescribed medication(s) which serve as indicators for adjusting therapeutic measures. Likewise, surgical patients transferred from a hospital to a skilled nursing facility while in the complicated, unstabilized postoperative period, e.g., after hip prosthesis or cataract surgery, may need continued close skilled monitoring for postoperative complications, and adverse reaction. Patients who, in addition to their physical problems, exhibit acute psychological symptoms such as depression, anxiety, or agitation, etc., may also require skilled observation and assessment by technical or professional personnel to assure their safety and/or the safety of others, i.e., to observe for indications of suicidal or hostile behavior. The need for services of this type must be documented by physicians' orders and/or nursing or therapy notes.

(3) *Patient education services.* Patient education services are skilled services if the use of technical or professional personnel is necessary to teach a patient self-maintenance. For example, a patient who has had a recent leg amputation needs skilled rehabilitation services provided by technical or professional personnel to provide gait training and to teach prosthesis care. Likewise, a patient newly diagnosed with diabetes requires instruction from technical or professional personnel to learn the self-administration of insulin or foot-care precautions, etc.

(b) *Services that qualify as skilled nursing services.* (1) Intravenous, intramuscular, or subcutaneous injections and hypodermoclysis or intravenous feeding;

(2) Levin tube and gastrostomy feedings;

(3) Nasopharyngeal and tracheostomy aspiration;

(4) Insertion and sterile irrigation and replacement of catheters;

(5) Application of dressings involving prescription medications and aseptic techniques;

(6) Treatment of extensive decubitus ulcers or other widespread skin disorder;

(7) Heat treatments which have been specifically ordered by a physician as part of active treatment and which require observation by nurses to adequately evaluate the patient's progress;

(8) Initial phases of a regimen involving administration of medical gases;

(9) Rehabilitation nursing procedures, including the related teaching and adaptive aspects of nursing, that are part of active treatment, e.g., the institution and supervision of bowel and bladder training programs.

(c) *Services which would qualify as skilled rehabilitation services.* (1) Ongoing assessment of rehabilitation needs and potential: Services concurrent with the management of a patient care plan, including tests and measurements of range of motion, strength, balance, coordination, endurance, functional ability, activities of daily living, perceptual deficits, speech and language or hearing disorders;

(2) Therapeutic exercises or activities: Therapeutic exercises or activities which, because of the type of exercises employed or the condition of the patient, must be performed by or under the supervision of a qualified physical therapist or occupational therapist to ensure the safety of the patient and the effectiveness of the treatment;

(3) Gait evaluation and training: Gait evaluation and training furnished to restore function in a patient whose ability to walk has been impaired by neurological, muscular, or skeletal abnormality;

(4) Range of motion exercises: Range of motion exercises which are part of the active treatment of a specific disease state which has resulted in a loss of, or restriction of, mobility (as evidenced by a therapist's notes showing the degree of motion lost and the degree to be restored);

(5) Maintenance therapy; Maintenance therapy, when the specialized knowledge and judgment of a qualified therapist is required to design and establish a maintenance program based on an initial evaluation and periodic reassessment of the patient's needs, and consistent with the patient's capacity and tolerance. For example, a patient with Parkinson's disease who has not been under a rehabilitation regimen may require the services of a qualified therapist to determine what type of exercises will contribute the most to the maintenance of his present level of functioning.

(6) Ultrasound, short-wave, and microwave therapy treatment by a qualified physical therapist;

(7) Hot pack, hydrocollator, infrared treatments, paraffin baths, and whirlpool; Hot pack hydrocollator, infrared treatments, paraffin baths, and whirlpool in particular cases where the patient's condition is complicated by circulatory deficiency, areas of desensitization, open wounds, fractures, or other complications, and the skills, knowledge, and judgment of a qualified physical therapist are required; and

(8) Services of a speech pathologist or audiologist when necessary for the restoration of function in speech or hearing.

(d) *Personal care services.* Personal care services which do not require the skills of qualified technical or professional personnel are not skilled services except under the circumstances specified in § 409.32(b). Personal care services include, but are not limited to, the following:

(1) Administration of routine oral medications, eye drops, and ointments;

(2) General maintenance care of colostomy and ileostomy;

(3) Routine services to maintain satisfactory functioning of indwelling bladder catheters;

(4) Changes of dressings for noninfected postoperative or chronic conditions;

(5) Prophylatic and palliative skin care, including bathing and application of creams, or treatment of minor skin problems;

(6) Routine care of the incontinent patient, including use of diapers and protective sheets;

(7) General maintenance care in connection with a plaster cast;

(8) Routine care in connection with braces and similar devices;

(9) Use of heat as a palliative and comfort measure, such as whirlpool and hydrocollator;

(10) Routine administration of medical gases after a regimen of therapy has been established;

(11) Assistance in dressing, eating, and going to the toilet;

(12) Periodic turning and positioning in bed; and

(13) General supervision of exercises which have been taught to the patient; including the actual carrying out of maintenance programs, i.e., the performance of the repetitive exercises required to maintain function do not require the skills of a therapist and would not constitute skilled rehabilitation services (see paragraph (c) of this section). Similarly, repetitious exercises to improve gait, maintain strength, or endurance; passive exercises to maintain range of motion in paralyzed extremities, which are not related to a specific loss of function; and assistive walking do not constitute skilled rehabilitation services.

§ 409.34 Criteria for "daily basis".

(a) To meet the daily basis requirement specified in § 409.31(b)(1) the following frequency is required:

(1) Skilled nursing services or skilled rehabilitation services must be needed and provided 7 days a week; or

(2) As an exception, if skilled rehabilitation services are not available 7 days a week those services must be needed and provided at least 5 days a week.

(b) A break of one or two days in the furnishing of rehabilitation services will not preclude coverage if discharge would not be practical for the one or two days during which, for instance, the physician has suspended the therapy sessions because the patient exhibited extreme fatigue.

§ 409.35 Criteria for "practical matter".

(a) *General considerations.* In making a "practical matter" determination, as required by § 409.31(b)(3), consideration must be given to the patient's condition and to the availability and feasibility of using more economical alternative facilities and services. However, in making that determination, the availability of Medicare payment for those services may not be a factor. Example: The beneficiary can obtain daily physical therapy from a physical therapist in independent practice. However, Medicare pays only the appropriate portion (after deduction of applicable deductible and coinsurance amounts) of the first $100 of services furnished by such a practitioner in a year. This limitation on payment may not be a basis for finding that the needed care can only be provided in a SNF.

(b) *Examples of circumstances that meet practical matter criteria.* (1) *Beneficiary's condition.* Inpatient care would be required "as a practical matter" if transporting the beneficiary to and from the nearest facility that furnishes the required daily skilled services would be an excessive physical hardship.

(2) *Economy and efficiency.* Even if the beneficiary's condition does not preclude transportation, inpatient care might be more efficient and less costly if, for instance, the only alternative is daily transportation by ambulance.

§ 409.36 Effect of discharge from posthospital SNF care.

If a beneficiary is discharged from a facility after receiving posthospital SNF care, he or she is not entitled to additional services of this kind in the same benefit period unless—

(a) He or she is readmitted to the same or another facility within 30 calendar days following the day of discharge (or, before December 5, 1980, within 14 calendar days after discharge); or

(b) He or she is again hospitalized for at least 3 consecutive calendar days.

Home Health Services

§ 409.40 Included services.

Subject to the requirements and conditions set forth in § 409.42, "home health services" means the following items and services:

(a) Part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse;

(b) Physical, occupational, or speech therapy;

(c) Medical social services provided under the direction of a physician;

(d) Part-time or intermittent services of a home health aide;

(e) Medical supplies (other than drugs and biologicals) and the use of medical appliances; and

(f) In the case of a home health agency (HHA) that is affiliated or under common control with a hospital, medical services provided by an intern or a resident-in-training of that hospital under a teaching program approved as provided in § 409.15.

§ 409.41 Excluded services.

(a) *Services that are not considered inpatient hospital services.* No service is included as a home health service if it would not be included as an inpatient hospital service under §§ 409.11—409.18.

(b) *Transportation.* Transportation required to take a homebound individual to a hospital, SNF, rehabilitation center or other place, to receive services that cannot be provided in the home, is not included as a home health service.

(c) *Housekeeping services.* The services of housekeepers or food service arrangements such as "meals-on-wheels" programs are not included as home health services.

§ 409.42 Requirements and conditions for home health services.

(a) *Basic rule.* The services specified in § 409.40 are covered by Medicare Part A only if the requirements of paragraphs (b) through (g) of this section are met.

(b) *Conditions the beneficiary must meet.* The beneficiary must be—

(1) Confined to the home or in an institution that is neither a hospital nor primarily engaged in providing skilled nursing or rehabilitation services;

(2) Under the care of a physican who is a doctor of medicine or osteopathy; and

(3) In need of intermittent skilled nursing care or physical or speech therapy or, effective July 1 through November 30, 1981, occupational therapy. After November 30, 1981, continued need for occupational therapy is not a basis for initial qualification for

home health services but does qualify a beneficiary for continued home health services even after he or she no longer needs intermittent skilled nursing care or physical or speech therapy.

(c) *Prior inpatient care requirement.* (1) For home health services furnished before July 1, 1981, the beneficiary must—

(i) Have received inpatient care in a participating or qualified hospital or SNF; and

(ii) Need intermittent skilled nursing care or physical or speech therapy for a condition for which he or she received inpatient hospital or posthospital SNF care.

(2) For home health services furnished after June 30, 1981, the requirements of paragraph (c)(1) of this section do not apply.

(d) *Plan of treatment requirements.* (1) The home health services must be furnished under a plan of treatment that is established and periodically reviewed by a doctor of medicine or osteopathy or, after December 31, 1980, by a doctor of podiatric medicine. A doctor of podiatric medicine may establish a plan of treatment only if that is consistent with the home health agency's policy and with the functions he or she is authorized to perform under State law.

(2) A plan of treatment established before July 1, 1981 must be established within 14 days after the individual's discharge from a hospital or SNF.

(3) For a plan of treatment established after June 30, 1981, the requirement of paragraph (d)(2) of this section does not apply.

(e) *Where the services must be furnished.* (1) The home health services must be furnished—

(i) On a visiting basis in the individual's home; or

(ii) If it is necessary to use equipment that cannot readily be made available in the home, on an outpatient basis in a hospital, a SNF, or a rehabilitation center that meets State and local health and safety standards.

(2) If an individual is brought to a facility in accordance with paragraph (e)(1)(ii) of this section, other services that could be furnished in the home may be furnished in the facility at the same time.

(f) *When the services must be furnished.* Before July 1, 1981, the home health services must be furnished within the time frames specified in § 409.61(d).

(g) *By whom the services must be furnished.* The home health services must be furnished by, or under arrangements made by a participating HHA.

§ 409.43 Home health service visit.

(a) *What constitutes a "visit".* A visit is charged each time a health worker furnishes home health services to the beneficiary.

(b) *Specific examples.* (1) If both a physical therapist and a visiting nurse furnish services in the home on the same day, two visits are charged.

(2) If a beneficiary has dressings changed twice in the same day, two visits are charged.

(3) If a beneficiary is brought to the hospital for hydrotherapy, and while there also receives speech therapy, two visits are charged.

(4) If a nurse furnishes several services during the same visit (e.g., skilled nursing care and home health aide services), only one visit is charged.

§ 409.44 Home health services under Medicare Part B.

Home health services are also provided under the supplementary medical insurance program, as set forth in Subpart B of Part 405 of this chapter.

§ 409.45 Option for beneficiaries who need physical or speech therapy.

A beneficiary who needs physical therapy or speech pathology services could, if he is also enrolled in Medicare Part B, receive them on an outpatient basis as a medical and other health service under Part B, and use the Part A and Part B home health visits for other purposes.

Scope of Benefits

§ 409.60 Benefit periods.

(a) *When benefit periods begin.* The initial benefit period begins on the day the beneficiary receives inpatient hospital or SNF services for the first time after becoming entitled to hospital insurance. Thereafter, a new benefit period begins whenever the beneficiary receives inpatient services upon admission to a participating hospital or SNF (or one that meets the requirements for participation), after he or she has, for a least 60 consecutive days, not been an inpatient in any hospital, or SNF, or other institution that primarily provides skilled nursing or rehabilitation services.

(b) *Relation of benefit period to benefit limitations.* The limitations specified in §§ 409.61 and 409.64, and the deductible and coinsurance requirements set forth in §§ 409.82 through 409.87 apply for each benefit period. The limitations of § 409.63 apply only to the initial benefit period.

§ 409.61 General limitations on amount of benefits.

(a) *Inpatient hospital services.* (1) *Regular benefit days.* Up to 90 days are available in each benefit period, subject to the limitations on days for psychiatic hospital services set forth in §§ 409.62 and 409.63.

(i) For the first 60 days (referred to in this subpart as *full benefit days*). Medicare pays the hospital for all covered services furnished the beneficiary, except for a deductible which is the beneficiary's responsibility. (Section 409.82 specifies the requirements for the inpatient hospital deductible.)

(ii) For the next 30 days (referred to in this subpart as *coinsurance days*), Medicare pays for all covered services except for a daily coinsurance amount, which is the beneficiary's responsibility. (Section 409.83 specifies the inpatient hospital coinsurance amounts.)

(2) *Lifetime reserve days.* Each beneficiary has a non-renewable lifetime reserve of 60 days of inpatient hospital services that he may draw upon whenever he is hospitalized for more than 90 days in a benefit period. Upon exhaustion of the regular benefit days, the reserve days will be used unless the beneficiary elects not to use them, as provided in § 409.65. For lifetime reserve days, Medicare pays for all covered services except for a daily coinsurance amount that is the beneficiary's responsibility. (See § 409.83.)

(3) *Order of payment for inpatient hospital services.* Medicare pays for inpatient hospital services in the following order.

(i) The 60 full benefit days;

(ii) The 30 coinsurance days;

(iii) The remaining lifetime reserve days.

(b) *Posthospital SNF care.* Up to 100 days are available in each benefit period after discharge from a hospital. For the first 20 days, Medicare pays for all covered services. For the 21st through 100th day, Medicare pays for all covered services except for a daily coinsurance amount that is the beneficiary's responsibility. (Section 409.85 specifies the SNF coinsurance amounts.)

(c) *Renewal of inpatient benefits.* The beneficiary's full entitlement to the 90 inpatient hospital regular benefit days, and the 100 SNF benefit days, is renewed each time he or she begins a benefit period. However, once lifetime reserve days are used, they can never be renewed.

(d) *Home health visits.* (1) Medicare pays for all covered home health services. There are no deductible or coinsurance requirements. (2) Before July 1, 1981, Medicare pays for up to 100 visits furnished—

(i) After the beginning of one benefit period and before the beginning of the next and

(ii) Within one year after the later of the following:

(A) The individual's most recent discharge from a hospital, following a stay of at least 3 consecutive days.

(B) The individual's most recent discharge from a SNF, following receipt of service for which he or she was entitled to have payment made.

(3) After June 30, 1981, the limitations of paragraph (d)(2) of this section do not apply.

§ 409.62 Lifetime maximum on inpatient psychiatric care.

There is a lifetime maximum of 120 days on inpatient psychiatric hospital service available to any beneficiary. Therefore, once an individual receives benefits for 190 days of care in a psychiatric hospital, no further benefits of that type are available to that individual.

§ 409.63 Reduction of inpatient psychiatric benefit days available in the initial benefit period.

(a) *Reduction rule.* (1) If the individual was an inpatient in a psychiatric hospital on the first day of Medicare entitlement and for any of the 150 days immediately before that first day of entitlement, those days are subtracted from the 150 days (90 regular days plus 60 lifetime reserve days) which would otherwise be available in the initial benefit period for inpatient psychiatric services in a psychiatric or general hospital.

(2) Reduction is required only if the hospital was participating in Medicare as a psychiatric hospital on the individual's first day of entitlement.

(3) The reduction applies only to the beneficiary's first benefit period. For subsequent benefit periods, the 90 benefit days, plus any remaining lifetime reserve days, subject to the 190 day lifetime limit on psychiatric hospital care, are available.

(b) *Application to general hospital days.* (1) Days spent in a general hospital before entitlement are not subtracted under paragraph (a) of this section even if the stay was for diagnosis or treatment of mental illness.

(2) After entitlement, all psychiatric care days, whether in a general or a psychiatric hospital, are counted toward the number of days available in the initial benefit period.

(c) *Examples:* (1) The individual was an inpatient of a participating psychiatric hospital for 20 days before the first day of entitlement and remained there for another 6 months. Therefore, 130 days of benefits (150 minus 20) are payable. Payment could be made for: 60 full benefit days, 30 coinsurance days, and 40 lifetime reserve days.

(2) During the 150-day period preceding Medicare entitlement, an individual had been a patient of a general hospital for 60 days of inpatient psychiatric care and had spent 90 days in a psychiatric hospital, ending with the first day of entitlement. During the initial benefit period, the beneficiary spent 90 days in a general hospital and received psychiatric care there. The 60 days spent in the general hospital for psychiatric treatment before entitlement do not reduce the benefits available in the first benefit period. Only the 90 days spent in the psychiatric hospital before entitlement reduce such benefits, leaving a total of 60 available psychiatric days. However, after entitlement, the reduction applies not only to days spent in a psychiatric hospital, but also to days of psychiatric treatment in a general hospital. Thus, Medicare payment could be made only for 60 of the 90 days spent in the general hospital.

(3) An individual was admitted to a general hospital for a mental condition and, after 10 days, transferred to a participating psychiatric hospital. The individual remained in the psychiatric hospital for 78 days before becoming entitled to hospital insurance benefits and for 130 days after entitlement. The beneficiary was then transferred to a general hospital and received treatment of a medical condition for 20 days. The 10 days spent in the general hospital during the 150-day pre-entitlement period have no effect on the inpatient hospital benefit days available to the individual for psychiatric care in the first benefit period, even though the general hospital stay was for a mental condition. Only the 78 days spent in the psychiatric hospital during the pre-entitlement period are subtracted from the 150 benefit days. Accordingly, the individual has 72 days of psychiatric care (150 days less 78 days) available in the first benefit period. Benefits could be paid for the individual's hospitalization during the first benefit period in the following manner. For the 130-day psychiatric hospital stay, 72 days (60 full benefit days and 12 coinsurance days), and for the general hospital stay, 20 days (18 coinsurance and 2 lifetime reserve days).

§ 409.64 Services that are counted toward allowable amounts.

(a) Except as provided in paragraph (b) of this section for lifetime reserve days, all covered inpatient days and home health visits are counted toward the allowable amounts specified in §§ 409.61–409.63 if—

(1) They are paid for by Medicare; or

(2) They would be paid for by Medicare if the following requirements had been met:

(i) A proper and timely request for payment had been filed; and

(ii) The hospital, SNF, or home health agency had submitted all necessary evidence, including physician certification of need for services when such certification was required; or

(3) They could not be paid for because the total payment due was equal to, or less than, the applicable deductible and coinsurance amounts.

(b) *Exception.* Even though the requirements of paragraph (a)(2) of this section are met, lifetime reserve days are not counted toward the allowable amounts if the beneficiary elected or is deemed to have elected not to use them as set forth in § 409.65.

§ 409.65 Lifetime reserve days.

(a) *Election not to use lifetime reserve days.* (1) Whenever a beneficiary has exhausted the 90 regular benefit days, the hospital may bill Medicare for lifetime reserve days unless the beneficiary elects not to use them or, in accordance with paragraph (b) of this section, is deemed to have elected not to use them.

(2) It may be advantageous to elect not to use lifetime reserve days if the beneficiary has private insurance coverage that begins after the first 90 inpatient days in a benefit period, or if the daily charge is only slightly higher than the lifetime reserve days coinsurance amount. In such cases, the beneficiary may want to save the lifetime reserve days for future care that may be more expensive.

(3) If the beneficiary elects not to use lifetime reserve days for a particular hospital stay, they are still available for a later stay. However, once the beneficiary uses lifetime reserve days, they can never be renewed.

(4) If the beneficiary elects not to use lifetime reserve days, the hospital may require him or her to pay for any services furnished after the regular days are exhausted.

(b) *Deemed election.* A beneficiary will be deemed to have elected not to use lifetime reserve days if the average daily charges for such days is equal to or less than the applicable coinsurance amount specified in § 409.83. A beneficiary would get no benefit from using the days under those circumstances.

(c) *Who may file an election.* An election not to use reserve days may be filed by—

(1) The beneficiary; or

(2) If the beneficiary is physically or mentally unable to act, by the beneficiary's legal representative. In addition, if some other payment source is available, such as private insurance, any person authorized under § 405.1664 of this chapter to execute a request for payment for the beneficiary may file the election.

(d) *Filing the election.* (1) The beneficiary's election not to use lifetime reserve days must be filed in writing with the hospital.

(2) The election may be filed at the time of admission to the hospital or at any time thereafter up to 90 days after the beneficiary's discharge.

(3) A retroactive election (i.e., one made after lifetime reserve days have been used because the regular days were exhausted), is not acceptable unless it is approved by the hospital.

(e) *Period covered by election.* An election not to use lifetime reserve days may apply to an entire hospital stay or to a single period of consecutive days in a stay, but cannot apply to selected days in a stay. For example, a beneficiary may restrict the election to the period covered by private insurance but cannot use individual lifetime reserve days within that period. If an election not to use reserve days is effective after the first day on which reserve days are available, it must remain in effect until the end of the stay, unless it is revoked in accordance with § 409.66.

§ 409.66 Revocation of election not to use lifetime reserve days.

(a) Except as provided in paragraph (c) of this section, a beneficiary (or anyone authorized to execute a request for payment, if the beneficiary is incapacitated) may revoke an election not to use lifetime reserve days during hospitalization or within 90 days after discharge.

(b) The revocation must be submitted to the hospital in writing and identify the stay or stays to which it applies.

(c) *Exceptions.* A revocation of an election not to use lifetime reserve days may not be filed—

(1) After the beneficiary dies; or

(2) After the hospital has filed a claim under the supplementary medical insurance program (Medicare Part B), for medical and other health services furnished to the beneficiary on the days in question.

§ 409.68 Guarantee of payment for inpatient hospital services furnished before notification of exhaustion of benefits.

(a) *Conditions for payment.* Payment may be for inpatient hospital services furnished a beneficiary after he or she has exhausted the coverage days if the following conditions are met:

(1) The services were furnished before HCFA or the intermediary notified the hospital that the beneficiary had exhausted the available days of coverage and was not entitled to have payment made for those services.

(2) At the time the hospital furnished the services, it was unaware that the beneficiary had exhausted the available days of coverage and could reasonably have assumed that he or she was entitled to have payment made for these services.

(3) Payment would be precluded solely because the beneficiary has no benefit days available for the particular hospital stay.

(4) The hospital claims reimbursement for the services and refunds any payments made for those services by the beneficiary or by another person on his or her behalf.

(b) *Limitations on payment.* (1) If all of the conditions in paragraph (a) of this section are met, Medicare payment may be made for plus the day of admission, and up to 6 weekdays thereafter, plus any intervening Saturdays, Sundays, and Federal holidays.

(2) Payment may not be made under this section for any day after the hospital is notified that the beneficiary has exhausted the available benefit days.

(c) *Recovery from the beneficiary.* Any payment made to a hospital under this section is considered an overpayment to the beneficiary and may be recovered from him or her under the provisions set forth elsewhere in this chapter.

§ 409.69 Amounts payable.

The amounts payable for Medicare Part A services are subject to the deductible and coinsurance requirements set forth in this subpart, and are generally based on "reasonable cost" determined in accordance with Part 405, Subpart D of this chapter. (See §§ 405.153(c)(2) and 405.158(a) for payment on a charge basis for certain services furnished by hospitals outside the United States or by hospitals not participating in Medicare.)

Deductibles and Coinsurance

§ 409.80 Inpatient deductible and coinsurance: General provisions.

(a) *What they are.* (1) The inpatient deductible and coinsurance amounts are portions of the cost of covered hospital or SNF services that Medicare does not pay.

(2) The hospital or SNF may charge these amounts to the beneficiary or someone on his or her behalf.

(b) *Changes in the inpatient deductible and coinsurance amounts.* (1) The law requires the Secretary to adjust the inpatient hospital deductible each year to reflect changes in the average cost of hospital care. In adjusting the deductible, the Secretary must use a formula specified in section 1813(b)(2) of the Act. Under that formula, the inpatient hospital deductible is increased each year by about the same percentage as the increase in the average Medicare daily hospital costs. The result of the deductible increase is that the beneficiary continues to pay about the same proportion of the hospital bill.

(2) Since the coinsurance amounts are, by statute, specific fractions of the deductible, they change when the deductible changes.

§ 409.82 Inpatient hospital deductible.

(a) *General provisions.* (1) The inpatient hospital deductible is a fixed amount chargeable to the beneficiary when he or she receives covered services in a hospital for the first time in a benefit period.

(2) Although the beneficiary may be hospitalized several times during a benefit period, the deductible is charged only once during that period. If the beneficiary begins more than one benefit period in the same year, a deductible is charged for each of those periods.

(3) For services furnished before January 1, 1982, the applicable deductible is the one in effect when the benefit period began.

(4) For services furnished after December 31, 1981, the applicable deductible is the one in effect during the calendar year in which the services were furnished.

(b) *Specific deductible amounts.* (1) The following chart specifies the deductible amounts for services furnished before January 1, 1982.

Benefit period began—	Amount of deductible
Before 1969	$40
in:	
1969	44
1970	52
1971	60
1972	68
1973	72
1974	84
1975	92
1976	104
1977	124
1978	144

Benefit period began—	Amount of deductible
1979	160
1980	180
1981	204

(2) The following chart specifies the deductible amounts for services furnished after December 31, 1981:

Services furnished in	Amount of deductible
1982	$260
1983	304

(c) *Exemption.* If the total hospital charge is less than the amount shown under paragraph (b)(1) or (b)(2) of this section, the deductible is the amount of the charge.

§ 409.83 Inpatient hospital coinsurance.

(a) *General provisions.* (1) Inpatient hospital coinsurance is the amount charegable to a beneficiary for each day after the first 60 days of inpatient hospital care in a benefit period.

(2) For each day from the 61st to the 90th day, the coinsurance amount is ¼ of the applicable deductible.

(3) For each day from the 91st to the 150th day (lifetime reserve days), the coinsurance amount is ½ of the applicable deductible.

(4) For coinsurance days before January 1, 1982, the coinsurance amount is based on the deductible applicable for the calendar year in which the benefit period began. The coinsurance amounts do not change during a beneficiary's benefit period even though the coinsurance days may fall in a subsequent year for which a higher deductible amount has been determined.

(5) For coinsurance days after December 31, 1981, the coinsurance amount is based on the deductible applicable for the calendar year in which the services were furnished. For example, if an individual starts a benefit period by being admitted to a hospital in 1981 and remains in the hospital long enough to use coinsurance days in 1982, the coinsurance amount charged for those days is based on the 1982 inpatient hospital deductible.

(b) *Specific coinsurance amounts.* (1) The following chart specifies the daily hospital coinsurance amounts for services furnished before January 1, 1982:

Benefit period began—	61st to 90th day—	91st to 150th day—
Before 1969	$10	$20
In:		
1968	11	22
1970	13	26
1971	15	30
1972	17	34
1973	18	36
1974	21	42
1975	23	46
1976	26	52
1977	31	62
1978	36	72
1979	40	80
1980	45	90
1981	51	102

(2) The following chart specifies the daily hospital coinsurance amounts for services furnished after December 31, 1981:

Services furnished in	61st to 90th day	91st to 150th day
1982	$65	$130
1983	76	152

(c) Exemptions. (1) If the actual charge to the patient for the 61st through the 90th day of inpatient hospital services is less than the applicable coinsurance amount shown in paragraph (b)(1) or (b)(2) of this section, the coinsurance amount is the actual charge per day. (2) If the actual charge to the patient for the 91st through the 150th day (lifetime reserve days) is less than the applicable coinsurance amount shown in paragraph (b)(1) or (b)(2) of this section for those days, the beneficiary is deemed to have elected not to use the days because he or she would not benefit from using them.

§ 409.85 Skilled nursing facility (SNF) care coinsurance.

(a) *General provisions.* (1) SNF care coinsurance is the amount chargeable to a beneficiary after the first 20 days of SNF care in a benefit period.

(2) For each day from the 21st through the 100th day, the coinsurance is ⅛ of the applicable inpatient hospital deductible.

(3) For coinsurance days before January 1, 1982, the coinsurance amount is based on the deductible applicable for the year in which the benefit period began. The coinsurance amounts do not change during a beneficiary's benefit period even though the coinsurance days may fall in a subsequent year for which a higher deductible amount has been determined.

(4) For coinsurance days after December 31, 1981, the coinsurance amount is based on the deductible applicable for the calendar year in which the services were furnished.

(b) Specific amounts of daily SNF coinsurance. (1) The following chart specifies the daily coinsurance amounts for posthospital SNF care furnished before January 1, 1982:

Benefit period began—	Daily amount
Before 1969	$5.00
In:	
1969	5.50
1970	6.50
1971	7.50
1972	8.50
1973	9.00
1974	10.50
1975	11.50
1976	13.00
1977	15.50
1978	18.00
1979	20.00
1980	22.50
1981	25.50

(2) The following chart specifies the daily SNF coinsurance amounts for services furnished after December 31, 1981:

Services furnished in	Daily amount
1982	$32.50
1983	38.00

(c) *Exemption.* If the actual charge to the patient is less than the applicable coinsurance amount shown under paragraph (b)(1) or (b)(2) of this section, the coinsurance is the actual charge per day.

§ 409.87 Blood deductible.

(a) *General provisions.* (1) As used in this section, packed red cells means the red blood cells that remain after plasma is separated from whole blood.

(2) A unit of packed red cells is treated as the equivalent of a unit of whole blood.

(3) Medicare does not pay for the first 3 units of whole blood or units of packed red cells that a beneficiary receives as an inpatient of a hospital or SNF during a benefit period. For example, if an individual receives 2 units of blood in a hospital and 3 units in a SNF during a single benefit period, the 2 units furnished in the hospital and the first unit furnished in the SNF would be the responsibility of the individual. Medicare would pay for the other 2 units furnished in the SNF.

(4) The deductible does not apply to other blood components such as platelets, fibrinogen, plasma, gamma globulin, and serum albumin, or to the cost of processing, storing, and administering blood.

(5) The blood deductible is in addition to the inpatient hospital deductible and daily coinsurance.

(6) There is also a separate Part B (supplementary medical insurance) blood deductible. Blood funished under Part B of Medicare cannot be applied to satisfy the Part A (hospital insurance) blood deductible and blood furnished under Part A of Medicare cannot be applied to satisfy the Part B blood deductible.

(b) *Beneficiary's responsibility for the first 3 units of whole blood or packed red cells.* (1) *Basic rule.* Except as specified in paragraph (b)(2) of this section, the beneficiary is responsible for the first 3 units of whole blood or packed red cells. He or she has the option of paying the hospital's charges for the blood or packed red cells or arranging for it to be replaced.

(2) *Exception.* The beneficiary is not responsible for the first 3 units of whole blood or packed red cells if the provider obtained that blood or red cells at no charge other than a processing or service charge. In that case, the blood or red cells is deemed to have been replaced.

(c) *Provider's right to charge for the first 3 units of whole blood or packed red cells.* (1) *Basic rule.* Except as specified in paragraph (c)(2) of this section, a provider may charge a beneficiary its customary charge for any of the first 3 units of whole blood or packed red cells.

(2) *Exception.* A provider may not charge the beneficiary for the first 3 units of whole blood or packed red cells in any of the following circumstances:

(i) The blood or packed red cells has been replaced.

(ii) The provider (or its blood supplier) receives, from an individual or a blood bank, a replacement offer that meets the criteria specified in paragraph (d) of this section. The provider is precluded from charging even if it or its blood supplier rejects the replacement offer.

(iii) The provider obtained the blood or packed red cells at no charge other than a processing or service charge and it is therefore deemed to have been replaced.

(d) *Criteria for replacement of blood.* A blood replacement offer made by a beneficiary, or an individual or a blood bank on behalf of a beneficiary, discharges the beneficiary's obligation to pay for deductible blood or packed red cells if the replacement blood meets the applicable criteria specified in Food and Drug Administration regulations under 21 CFR Part 640, i.e.—

(1) The replacement blood would not endanger the health of a recipient; and

(2) The prospective donor's health would not be endangered by making a blood donation.

§ 409.89 Exemption of kidney donors from deductible and coinsurance requirements.

The deductible and coinsurance requirements set forth in this subpart do not apply to any services furnished to an individual in connection with the donation of a kidney for transplant surgery.

PART 430—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

F. Part 430 is amended as set forth below:

1. The authority statement is revised to read as follows:

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1320).

§ 430.1 [Removed. See §§ 400.200 and 400.203 of this chapter.]

2. The text of § 430.1 is revised and transferred to new §§ 400.200 and 400.203 and the table of contents is amended to reflect this change.

PART 440—SERVICES: GENERAL PROVISIONS

G. Part 440 is amended as set forth below:

1. The authority statement is revised to read as follows:

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

2. Section 440.40(a)(1)(i) is revised by revising the cross references, to read as follows:

§ 440.40 Skilled nursing facility services for individuals age 21 or older (other than services in an institution for tuberculosis or mental diseases). EPSDT, and family planning services and supplies.

(a) *Skilled nursing facility services.* (1) "Skilled nursing facility for individuals age 21 or older, other than services in an institution for tuberculosis or mental diseases, " means services that are—

(i) Needed on a daily basis and required to be provided on an inpatient basis under §§ 409.31–409.35 of this chapter.

* * * * *

(Catalog of Federal Domestic Assistance Program No. 13.714, Medical Assistance Programs; No. 13.773, Medicare—Hospital Insurance; and No. 13.774, Medicare—Supplementary Medical Insurance)

Dated: November 24, 1982.

Carolyne K. Davis,

Administrator, Health Care Financing Administration.

Approved: January 27 ,1983.

Richard S. Schweiker,

Secretary.

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DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

50 CFR Part 671

[Docket No. 30310-36]

Tanner Crab Off Alaska

Correction

In FR Doc. 83-6677 beginning on page 10846 in the issue of Tuesday, March 15, 1983, make the following correction on page 10847: In the second column, the fifth line, the first word should read "Fishing".

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