COPYRIGHT ROYALTY TRIBUNAL

37 CFR Part 307

[Docket No. CRT 87-3-87MRA]

1987 Adjustment of the Mechanical Royalty Rate

AGENCY: Copyright Royalty Tribunal.

ACTION: Final rule.

SUMMARY: This rule adopts a mechanism for adjusting the mechanical royalty rate every two years, from 1987 to 1997, based upon changes in the Consumer Price Index. This rule is based upon a proposal submitted by parties with a significant interest in the rate.

EFFECTIVE DATE: July 15, 1987.

FOR FURTHER INFORMATION CONTACT: Robert Cassler, General Counsel, Copyright Royalty Tribunal, 1111 20th Street NW., Suite 450, Washington, DC 20036, (202) 653-5175).

SUPPLEMENTARY INFORMATION: Sections 801(b)(1) and 804 of the Copyright Act of 1976 authorize the Copyright Royalty Tribunal (Tribunal) to adjust the mechanical royalty rate in 1987 upon receiving a petition from a party with a significant interest in the royalty rate. On March 18, 1987, the Tribunal received such a petition from the National Music Publishers' Association, Inc., The Songwriters Guild of America, and the Recording Industry Association of America, Inc. On April 7, 1987, the Tribunal proposed to adjust the mechanical royalty rate according to the mechanism provided by the parties in their petition. *Notice of Proposed Rulemaking*, Docket No. 87-3-87MRA, 52 FR 11096 (April 7, 1987). Briefly stated, the proposed rule calls for adjustments of the mechanical royalty rate to be published in the **Federal Register** every two years (November 1, 1987, November 1, 1989, November 1, 1991, November 1, 1993, November 1, 1995). The adjustment would be based solely upon changes in the Consumer Price Index (CPI), except when the CPI has declined, in which case the mechanical rate would remain the same, or when the Index has risen by more than 25%, in which case the mechanical rate adjustment would be no greater than 25%.

The tribunal received joint comments filed by the National Music Publishers Association, Inc., The Songwriters Guild of America, and the Recording Industry Association of America, Inc. supporting the proposal. Similarly, the Tribunal received comments from SESAC, Inc., a performing rights society which also represents mechanical rights for a significant number of its publisher affiliates, and from Music Royalties Ltd., a company representing the mechanical rights in approximately 50,000 musical compositions. SESAC, Inc. and Music Royalties Ltd. support the proposed rule. The proposal is therefore adopted unchanged as a final rule.

List of Subjects in 37 CFR Part 307

Copyright, Music, Recordings.

PART 307—[AMENDED]

For the reasons set forth in the preamble, the Tribunal amends 37 CFR Part 307 as follows:

1. The authority citation for Part 307 continues to read as follows:

Authority: 17 U.S.C. 801(b)(1) and 804.

§ 307.3 [Amended]

2. Section 307.3(a) is amended by removing the words "paragraphs (b) and (c) of this section." from the end, and by adding in their place the words "paragraphs (b), (c), (d) and (e) of this section."

3. Section 307.3(b) is amended by removing the words "paragraph (c) of this section." and adding in their place the words "paragraphs (c), (d) and (e) of this section."

4. Section 307.3(c) is amended by adding the words ", subject to further adjustment pursuant to paragraphs (d) and (e) of this section." at the end.

5. A new § 307.3(d) is added to read as follows:

* * * * *

(d)(1) On November 1, 1987, the Copyright Royalty Tribunal (CRT) shall publish in the **Federal Register** a notice of the percent change in the Consumer Price Index (all urban consumers, all items) (CPI) from the Index published for December, 1985 to the Index published for September, 1987, and the underlying calculations.

(2) On the same date as the notice is published pursuant to paragraph (d)(1) of this section, the CRT shall publish in the **Federal Register** revised compulsory license royalty rates which shall adjust the amounts set forth in § 307.3(c) in direct proportion to the percent change in the CPI determined as provided in paragraph (d)(1) of this section, rounded to the nearest 1/20th of a cent; provided however, that:

(i) The adjusted rates shall be no greater than 25% more than the amounts set forth in § 307.3(c); and

(ii) The adjusted rates shall be no less than the amounts set forth in § 307.3(c).

(3) The revised royalty rates for the compulsory license adjusted pursuant to this paragraph (d) shall become effective for every phonorecord made and distributed on or after January 1, 1988, subject to further adjustment pursuant to paragraph (e) of this section.

6. A new § 307.3(e) is added to read as follows:

* * * * *

(e)(1) On November 1, 1989, and each November 1 biennially thereafter until November 1, 1995 (that is, November 1, 1991, 1993 and 1995), the CRT shall publish in the **Federal Register** a notice of the percent change in the CPI from the Index published for the September two years earlier to the Index published for the September of the year in which such notice is published, and the underlying calculations.

(2) On the same date as the notice is published pursuant to this paragraph (e)(1), the CRT shall publish in the **Federal Register** revised compulsory license royalty rates which shall adjust the amounts then in effect pursuant to § 307.3(d) or this paragraph (e), as the case may be, in direct proportion to the percent change in the CPI determined as provided in paragraph (e)(1) of this section, rounded to the nearest 1/20th of a cent; provided, however, that:

(i) The adjusted rates shall be no greater than 25% more than the rates then in effect; and

(ii) The adjusted rates shall be no less than the amounts set forth in § 307.3(c).

(3) The revised royalty rates for the compulsory license adjusted pursuant to this paragraph (e) shall become effective for every phonorecord made and distributed on or after January 1 of the year following that in which such notice is published; that is, on January 1, 1990, 1992, 1994 and 1996, respectively.

Dated: June 9, 1987.

J.C. Argetsinger,

Chairman.

[FR Doc. 87-13599 Filed 6-12-87; 8:45 am]

BILLING CODE 1410-09-M

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 52

[A-8-FRL 3218-6]

Approval and Promulgation of State Implementation Plans; Colorado Prevention of Significant Deterioration Regulation; Correction

AGENCY: Environmental Protection Agency.

ACTION: Final rule; correction.

SUMMARY: The purpose of this notice is to correct the final rulemaking for the Colorado Prevention of Significant Deterioration (PSD) Regulation published on February 13, 1987 (52 FR 4622) and on September 2, 1986 (51 FR 31125). Language in 40 CFR 52.343 is being revised to clarify that EPA has retained authority to permit under 40 CFR 52.21 all sources that constructed prior to the September 2, 1986 approval of the Colorado PSD program. This correction is needed because the Colorado PSD regulation only allows Colorado to issue permits for sources that apply for a permit after EPA approval of the Colorado PSD program. Neither EPA nor Colorado intended to create any gaps in the PSD program through EPA approval of the Colorado regulation.

DATE: This action will be effective immediately on June 15, 1987.

FOR FURTHER INFORMATION CONTACT: Dale Wells, Air Programs Branch, Environmental Protection Agency, One Denver Place, Suite 500, 999 18th Street, Denver, Colorado 80202-2405, (303) 293-1773.

List of Subjects in 40 CFR Part 52

Air pollution control, Ozone, Sulfur oxides, Nitrogen dioxide, Lead, Particulate matter, Carbon monoxide, and Hydrocarbons, Incorporation by reference.

Dated: June 5, 1987.

James J. Scherer,

Regional Administrator.

PART 52—[AMENDED]

Part 52, Chapter I, Title 40 of the Code of Federal Regulations is amended as follows:

Subpart G—Colorado

1. The authority citation for Part 52 continues to read as follows:

Authority: 42 U.S.C. 7401-7642.

2. Section 52.343 is amended by adding paragraph (a)(10) to read as follows:

§ 52.343 Significant deterioration of air quality.

* * * * *

(a) * * *

(10) Sources that received permits from EPA or constructed prior to September 2, 1986.

* * * * *

[FR Doc. 87-13591 Filed 6-12-87; 8:45 am]

BILLING CODE 6560-50-M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 405, 409 and 442

[BERC-258-F]

Medicare and Medicaid Programs; Benefit Period Determinations, Drug Regimen Reviews and Other Technical Changes

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

ACTION: Final rule.

SUMMARY: Under the Hospital Insurance Program (Medicare—Part A), payment for covered inpatient hospital and skilled nursing facility (SNF) services is available for a limited number of days during each benefit period or "spell of illness." Current Medicare regulations reflect the statutory provision under section 1861(a) of the Social Security Act (Act) that a beneficiary's benefit period begins on the day he or she is furnished inpatient hospital or SNF services and ends when he or she has not been "an inpatient of a hospital nor an inpatient of a skilled nursing facility" (as defined under sections 1861(e)(1) and (j)(1) of the Act, respectively) for 60 consecutive days.

These final regulations: (1) Specify that a beneficiary is an "inpatient" of a SNF and is therefore prolonging a spell of illness in a SNF only if the care received by the beneficiary meets skilled level of care conditions and (2) establish certain presumptions which Medicare intermediaries may use in determining whether skilled level of care conditions have been met during a SNF stay.

These regulations also provide that a pharmacist must perform drug regimen reviews in intermediate care facilities (ICFs). In addition § 405.702 of the regulations is amended to remove certain cross-references that are now outdated and unnecessary.

EFFECTIVE DATE: These regulations are effective July 15, 1987.

FOR FURTHER INFORMATION CONTACT:

Thomas Hoyer (Benefit Period Determinations and Drug Regimen Reviews) (301) 594-9446.

Luisa Iglesias (Other Technical Changes) (202) 245-0838.

SUPPLEMENTARY INFORMATION:

I. Benefit Period Determinations

A. Statutory Background

Under the Hospital Insurance Program (Medicare—Part A), payment for covered inpatient hospital and SNF services is available for a limited number of days during each "spell of illness" or benefit period. (Payment is subject to applicable deductible and coinsurance amounts as set forth in section 1813(a) of the Social Security Act (Act).) Once a beneficiary has exhausted that allotted number of days (up to 150 days for inpatient hospital care, if the 60 lifetime reserve days are used, and 100 days for SNF care), no further Part A program payment is available for those services until the beneficiary ends that benefit period and begins a new one (section 1812(a) of the Act).

Under section 1861(a)(1) of the Act, a beneficiary's "spell of illness" begins on the day he or she is furnished inpatient hospital or SNF services and, under section 1861(a)(2) of the Act, ends when he or she has not been an inpatient of a hospital or SNF for 60 consecutive days. The law does not limit the number of benefit periods an individual may have, provided each prior period has ended.

The material following section 1861(j)(15) of the Act specifies that for purposes of determining when a benefit period ends under section 1861(a)(2), a SNF is defined by section 1861(j)(1) of the Act. This latter provision defines a SNF as a facility that—"Is primarily engaged in providing to inpatients:

(A) Skilled nursing care and related services for patients who require medical or nursing care; or

(B) Rehabilitation services for the rehabilitation of injured, disabled, or sick persons."

Also, the material following section 1861(e)(9) of the Act specifies that for purposes of section 1861(a)(2), a hospital is any institution which meets the requirements of section 1861(e)(1) of the Act. Basically, that latter provision defines a hospital as an institution primarily engaged in providing to inpatients diagnostic and therapeutic services, or rehabilitation services.

Therefore, under the law, the application of the terms "SNF" and "hospital" for purposes of ending a

benefit period is not limited to facilities which participate in Medicare or to those that are fully qualified to participate, but have chosen not to participate. Any facility meeting the broad definition of hospital or SNF is considered a hospital or SNF, as appropriate, in relation to a benefit period.

B. Program Experience

In 1967, we developed criteria to be used to assess whether a facility meets the definition of a SNF under section 1861(j)(1) of the Act, and, therefore, would be of a type in which a continued stay would prolong a beneficiary's benefit period. These criteria were published in section 3412 of the Medicare "State Operations Manual" and in the **Federal Register** as a Notice of HCFA Ruling (HCFA 83–2) December 3, 1982 (47 FR 54551). In response to a court decision (*Kron* v. *Heckler*, Civil Action Number 90–1332 (E.D. Louisiana, October 17, 1983)), the criteria for benefit period determinations were amended to exclude facilities licensed or certified solely as ICFs from status as SNFs under section 1861(j)(1) of the Act. The amended criteria for benefit period determinations were published in HCFA Ruling 83–3 (March 22, 1984, 49 FR 10710).

The Medicare program has continually maintained that it is the type of facility in which a beneficiary resides rather than the care he or she receives that determines whether or not a benefit period has ended. This has meant that if a beneficiary was *in* a hospital meeting the section 1861(e)(1) definition or *in* an SNF meeting the section 1861(j)(1) definition, the beneficiary was considered an "inpatient" of those facilities for purposes of benefit period determinations, regardless of the level of care actually received by the beneficiary.

Some Federal district courts have supported this view. See *Stoner* v. *Califano*, 458 F. Supp. 781 (E.D. Mich. 1978) and *Brown* v. *Richardson*, 367 F. Supp. 377 (W.D. Pa. 1973). However, four Federal circuit courts have concluded that the type of care provided to the beneficiary in a SNF should affect the ending of benefit periods.

In general, the latter decisions have concluded that, contrary to current Medicare policy, a beneficiary can be an "inpatient" of a SNF for purposes of benefit period determinations only if the beneficiary is receiving skilled care.

Based on these decisions, a patient residing in a SNF but not receiving skilled care would be subject to different benefit period determinations than before. Before the decisions, the patient's presence in the SNF would have continued his or her benefit period so that, while no new deductible would be required upon admission to a hospital, the patient would increasingly risk being liable upon readmission for the coinsurance associated with the 61st to the 90th day and the 91st to 150th day in a single benefit period. After the 150th day of hospital care, the patient's eligibility for Medicare hospital payments would end and could not be renewed if the patient remained a resident of the SNF after discharge from the hospital. Based on the decisions, a patient residing in a SNF but not receiving skilled care could begin new benefit periods and, as a result be subject to paying a new inpatient deductible as well as having the advantage of a renewed benefit period and reduced exposure to the risk of incurring coinsurance costs.

C. Proposed Rule

In view of these court decisions, we implemented revised procedures for making benefit determinations in the States and Federal jurisdictions under the courts' jurisdictions. We also began to prepare the proposed rule which we published in the **Federal Register** on May 16, 1986 (51 FR 17997) with respect to benefit period determinations, which would provide for nationwide implementation of these principles. We also included an unrelated change concerning drug regimen reviews and other technical changes. (See sections II. and III. for proposals regarding drug regimen reviews and other technical changes.)

1. Skilled Level of Care Requirement

(The proposed regulations would not affect the current definitions of "hospital" as used in section 1861(e)(1) and "SNF" as used in section 1861(j)(1). HCFA Rulings 83–2 and 83–3 would remain in effect.)

We proposed to amend § 409.60 of the regulations to specify that for purposes of ending a benefit period, a beneficiary is an "inpatient" of a SNF only if the beneficiary is receiving skilled nursing care, that is, if the beneficiary's care in the SNF meets the skilled level of care requirements contained in § 409.31(b)(1) and (3) of current regulations. Section 409.31(b)(1) provides that the beneficiary must require skilled services on a daily basis and § 409.31(b)(3) provides that the daily skilled services must be ones that, as a practical matter, can only be provided in a SNF on an inpatient basis. This means that a beneficiary is an "inpatient" of a SNF only if the beneficiary receives skilled nursing or rehabilitation services (already defined in regulations at § 409.31(a), and further delineated in §§ 409.32 and 409.33) that he or she requires on a daily basis (§ 409.34) and that, as a practical matter, can only be provided on an inpatient basis (§ 409.35).

2. Presumptions in Applying the Level of Care Requirements

a. General

We proposed to use seven presumptions to aid in administering the proposal that a beneficiary can be considered an "inpatient" of a SNF only if he or she is receiving a skilled level of care. Those seven presumptions were intended to cover every situation concerning a beneficiary's prior stay in a SNF, so that in all cases, the presumptions can serve to characterize (at least initially) the level of care status of a prior SNF stay.

Four of the presumptions are based on prior claims determinations that, if correct, are a good characterization of whether skilled care was provided. Three of the presumptions are based on prior claims determinations that may be subject to differing interpretations.

We decided to use these presumptions for several reasons. A major reason was administrative efficiency. All these presumptions make use of previous Medicare and Medicaid claims determinations relating to the issue. Use of presumptions prevents duplication of effort in many cases. Also, we do not believe that a beneficiary should benefit from two different characterizations of the same SNF stay for payment purposes. For example, if a Medicare or Medicaid payment was made for a prior SNF stay and was not challenged by the patient, we believe that determination should also be used as the basis for characterizing the stay for benefit period purposes.

It should be noted that the use of these presumptions does not result in determinations about whether inpatient hospital or SNF care is covered for purposes of Medicare payment. The presumptions are used exclusively to assist Medicare intermediaries in determining whether a patient who has been in an SNF begins a new benefit period upon admission to a hospital or remains in the same benefit period. Determinations about payment for the care in the SNF are made separately by the intermediary (when a claim is submitted) or by a State's Medicaid program.

b. Presumptions entirely based upon the accuracy of prior claims determinations

These four presumptions set forth in the proposed rule are based on prior claims payment determinations that, if correct, are a good characterization of whether skilled care was or was not provided. As stated in the proposal, the benefit period determinations resulting from these presumptions can only be changed if the beneficiary successfully appeals the prior claims determination upon which the presumption is based or if the payer properly reverses its earlier determination. The four presumptions are that—

(1) A beneficiary's care in an SNF met the skilled level of care requirements if Medicare or Medicaid made SNF benefit payments for that care (but not under Medicare limitation of liability rules at § 405.330(a), under Medicare grace day rules at § 405.330(b), or under any State Medicaid rules providing for SNF payment for administratively necessary days (ANDs) not meeting the skilled level of care requirements);

(2) A beneficiary's care in an SNF will be considered to be an skilled level of care if an SNF claim was paid under section 1879(e) of the Act;

(3) A beneficiary's care in an SNF did not meet the skilled level of care requirements if Medicare payment was made for the SNF care under the limitation of liability rules at § 405.330(a) or the grace day rules at § 405.330(b); and

(4) A beneficiary's care in an SNF did not meet the skilled level of care requirements if a Medicaid SNF claim was denied on the grounds that the care was not at the SNF level of care (even if paid under any State Medicaid rules which provide for payment for ANDs not meeting the skilled level of care requirements).

Each of these presumptions is triggered by virtue of there having been a prior Medicare or Medicaid payment decision which required a level-of-care finding.

c. Other presumptions

We proposed to use three presumptions that can be challenged by the beneficiary because the prior claims determination may be subject to another interpretation with respect to the current benefit period determination. We proposed to presume that—

(5) A beneficiary's care in a SNF meets the skilled level of care requirements if a Medicare or Medicaid claim for the SNF care was denied on other than level of care grounds (for example, denied because the three day prior hospital stay requirement was not met);

(6) A beneficiary's care in a SNF did not meet the skilled level of care requirements if a Medicare SNF claim was denied on level of care grounds and payment was not made under limitation of liability or grace day rules at § 405.330; and

(7) A beneficiary's care in a SNF (including a nonparticipating SNF) did not meet the skilled level of care requirements if no Medicare or Medicaid SNF claim was submitted for the SNF stay.

Beneficiaries would be notified that they could present documentation (for example, medical records and statements of physicians and nurses regarding the services needed and received) to challenge the presumption.

As set forth in the proposed rule, when these presumptions are applicable, Medicare beneficiaries would (in the context of the initial Medicare determination of the current claim) be advised of their opportunity to rebut the presumptions regarding any prior SNF stays. These appeals opportunities would exist in the context of appealing determinations, made under Title 42, Part 405, Subpart G, for the current claim (that is, the claim for which looking back at the status of the prior SNF stay can affect the beneficiary's benefit period status). In connection with the appeals opportunities set forth, we also proposed to amend § 405.704(b)(10) to make clear that initial determinations also include determinations made under the presumptions established under proposed § 409.60(c)(2).

d. Prior stay determinations—one finding only

Our proposal provided that the Medicare program would recognize only one level of care status finding (made under the Mediare or Medicaid programs) for any given day of care in a SNF; that is, that a day should not, for example, be considered as covered for one purpose and paid for under Medicare and then later considered as non-covered for purposes of establishing a new benefit period. This would apply only to days of care to which a prior claims determination specifically applies, not to days before or after the period for which the determination was made.

e. Effective date

We proposed that the regulations changes set forth in section I.C. above would be applied only to those claims for which determinations have not yet become final; that is, no longer subject to appeal (under Part 405, Subpart G), on or after the effective date of the final rule.

II. Drug Regimen Reviews

A. Background

The Medicare SNF regulations (§ 405.1127(a)), and the Medicaid SNF regulations (§ 442.202(c)) by reference to Part 405, Subpart K, require that a pharmacist perform a monthly drug regimen review on each patient in the SNF. However, under Medicaid regulations located at 42 CFR 442.336(a), in ICFs, these monthly reviews must be performed by a registered nurse. This presents a problem for some facilities dually certified as both a SNF and an ICF. A dually certified facility might find it administratively more efficient to designate either a pharmacist or a registered nurse to conduct reviews for all its patients regardleess of the level of care.

B. Proposal

In recognition of this situation and in order to provide flexibility for SNFs and ICFs, we proposed in our May 16 rule to modify §§ 405.1127(a) and 442.336(a) of the regulations to permit either a pharmacist or a registered nurse to conduct these reviews at the option of the facility

III. Technical Changes

We also proposed to make technical changes to 42 CFR 405.702 (as a result of other amendments to regulations) to remove two cross-references in that section

On September 1, 1983, we published in the **Federal Register** a final rule with comment period that revised § 405.401(c) of the regulations (48 FR 39809). The old paragraph (c) dealt with intermediaries in general, but the current paragraph (c) as amended by the rule (and on September 30, 1986 (41 FR 34790) recodified as § 413.1 (c)) now deals with outpatient maintenance dialysis and related services. Therefore, in the first sentence of § 405.702, we proposed to remove, as outdated and unnecessary, the parenthetical reference "(see § 405.401(c))". Also, as a result of regulations published on April 4, 1980 (45 FR 22935), certain sections of regulations formerly appearing in Title 42 under Part 405 were redesignated as Part 489. For the same reasons as above, we proposed to amend the second sentence of § 405.702 to remove the parenthetical "(see § 405.605)".

IV. Comments

A. Benefit Period Determinations

We received a variety of comments on the proposed rule, primarily from groups which represent beneficiaries and providers, and comments from an organization that represents intermediaries. Two of the nursing home organizations and a group representing beneficiaries supported the use of presumptions but made comments about them and noted that we would need to reexamine them in the light of experience to assure that they are operating as anticipated. The comments and responses to those comments are as follows:

1. Presumption 1

Comment: We have learned that, as a practical matter, there are some cases in which the same SNF stay may be subjected to conflicting Medicare and Medicaid claims determinations. For example, a SNF stay may be denied by a Medicare intermediary as not meeting the skilled levels of care requirements and subsequently billed to the Medicaid agency and paid as covered skilled nursing care.

Response: In such cases we believe that the difference in the determinations must be resolved on the side of the Medicare intermediary. Accordingly, we have amended the language of presumption 1 (contained at § 409.60(c)(1)(i)) to indicate that, in such cases, presumption 6 (contained at § 409.60(c)(2)(ii)), relating to SNF claims denied by Medicare as not meeting the skilled care criteria, should be applied

2. Presumption 2

Comment: One commenter asserted that the presumption contained in 42 CFR 409.60(c)(1)(ii) is inappropriate because it violates the intent of *Kron v. Heckler*. The presumption is that a patient required and received skilled care when his or her claim was paid pursuant to section 1879(e).

Response: We believe that the commenter misunderstood the presumption. Section 1879(e) of the Act provides that payment may be made in cases where a patient who required covered care was erroneously transferred from a bed in a participating facility (that is, a facility certified as a SNF) to a noncertified bed in the same facility (that is, a bed in a "distinct part" not certified as a SNF) as a result of an error made by an intermediary, utilization review committee, or peer review organization. The effect of our presumption is to recognize that such payments, which are only made when it is demonstrated upon appeal that skilled care was needed and given, create a presumption that the patient received skilled care. In our explanatory preamble material, we noted that this presumption works only in facilities which are SNFs with noncertified beds, not facilities which are distinct-part ICFs. We pointed out that *Kron v. Heckler* had led us to establish a test for benefit period purposes that excludes such facilities from being considered SNFs and, by implication, its inpatients from being inpatients of a SNF. The commenter apparently believes that the new distinction we are making in this regulation pursuant to *Mayburg v. Heckler* and other cases should extend to all settings so that a patient's level of care would determine his or her spell of illness status regardless of the institutional setting. This is not the case. All of these presumptions relate to the class of patients who are actually in SNFs. They are not to be applied to patients who are not in SNFs because they clearly are ending a spell of illness by virtue of their indisputable physical location.

3. Presumption 3

Comment: One commenter challenged the presumption in 42 CFR 409.60(c)(1)(iii). This presumption is that care will be presumed not to be skilled if a SNF claim has been paid under section 1879 of the law, the waiver of liability provision (§ 405.330). The commenter's contention is that Medicare claims determinations are so often incorrect that they cannot be relied upon to serve as the basis of presumptions.

Response: We do not agree with the commenter. Although reference was made in the comment to various articles challenging the consistency of claims determinations by intermediary staff relating to skilled nursing facility care, HCFA has never accepted these conclusions. Moreover, to accept this view is inconsistent with the basic operation of the statute, which assumes that final determinations relating to coverage will be made and will be assumed to be correct unless there is an appeal and a reversal of the determination. While it is true that claims determinations do require the application of medical judgment to individual cases and that medical opinions may vary, it is also true, as the commenter implies, that one result is the payment of some claims which another medical reviewer may have denied. We believe that the existing appeals process is the appropriate mechanism for challenging a claims determination and that, once a determination becomes final, it is appropriate to rely upon its accuracy to provide the basis for a presumption.

4. Presumption 5

Comment: Two commenters challenged the presumption at 42 CFR 409.60(c)(2)(i). This was the presumption that a patient received skilled care if a denial were made on technical (e.g., the patient did not have a necessary 3-day hospital qualifying stay) rather than medical grounds. The commenter challenged this presumption on the following bases. First, intermediaries tend to review claims first for compliance with technical requirements and, if a denial is made for a technial reason, do not examine the claim further to make medical judgments. Second, that patients may frequently enter SNFs for skilled care or unskilled care when there is no Medicare or Medicaid coverage and this presumption would cause them to extend their spells of illness. Finally, intermediaries might manipulate denial patterns so that technical, rather than medical, denials were made as a means of reducing Medicare expenditures.

Response: We disagree with the commenters. On the first issue, we would note that this is a presumption open to challenge and the patient is so advised when he or she receives the claims determination. Thus, to the extent that the presumption is inaccurate, patients may challenge and rebut it, thus suffering no harm. In addition, we would note that we designed this presumption so that it would work to the advantage of most beneficiaries. That is, few patients use large numbers of hospital days and the vast majority of patients benefit by remaining in the same benefit period because they do not become liable for payment of a new deductible. Thus, this presumption often benefits a patient. Finally, we would not expect our intermediaries to make determinations in the manner suggested and would certainly not order them to do so. For these reasons, we believe the presumption should remain as proposed.

5. Presumption 7

Comment: One commenter suggested that the presumption at 42 CFR 409.60(c)(2)(iii) be omitted. This presumption is that skilled care was not rendered if no Medicare or Medicaid claim was submitted for the care. The commenter argued that this presumption could disadvantage private pay patients or patients of nursing homes that do not participate in the Medicare program. The commenter also suggested that it is difficult to obtain "no payment" bills

from nursing homes (such bills generate denials that trigger other presumptions). Fnally, the commenter noted that nursing homes which do not bill because they believe skilled care was not rendered may be mistaken so that the failure to bill cannot be considered a reliable indicator that unskilled care was rendered.

Response: We acknowledge that the factors cited by the commenter could lead to the need to challenge this presumption and it is for that reason that we have made it open to dispute by the beneficiary. We would note that the fact that a patient has remained in a nursing home for some time without either being discharged or being reinstitutionalized indicates a stable condition is probable and custodial (rather than skilled) care is likely to be received. If this is not the case, the patient may challenge the presumption so that payment may be made. Thus, we do not believe that this presumption should be eliminated or reversed.

6. Christian Science Sanitoria

Comment: One commenter noted that the proposed rule did not mention Christian Science sanitoria, which may provide covered hospital or SNF care under current law. It was suggested that this set of presumptions be made applicable to patients in these sanatoriums.

Response: We agree. We will amend the language of the regulation to make reference to skilled nursing care furnished by a SNF described in section 1861(y) of the Act.

7. Presumption—Challenges

Comment: One commenter maintained that these presumptions will almost never be challenged by beneficiaries, citing the fact that very few Medicare determinations are currently appealed.

Response: We do not agree. There is no need for a patient to appeal a determination if there is no prospect of liability for the cost of care; however, in the instances involved here, the only patients who may be disadvantaged are the patients who may face the prospect of paying coinsurance for hospital care or paying a new inpatient hospital deductible or exhausting hospital or SNF benefits under a benefit period. These patients will learn of their impending liability in a timely manner. As a result, we believe that patients will have the necessary incentive to initiate appeals in cases where they believe that the claims determinations have not been correct.

Comment: One commenter recommended that all the presumptions be subject to challenge directly and objected to the fact that the presumptions in 42 CFR 409.60(c)(1) may only be altered when the claims determination upon which they are based is appealed and reversed. Another commenter recommended that we direct intermediaries to reopen and reexamine automatically those prior determinations upon which these presumptions are based.

Response: We do not agree. As we have noted elsewhere in this preamble, we believe that the statutory appeals mechanism for Medicare claims is adequate and that it is appropriate to rely upon final claims determinations in making presumptions about current claims. Whenever a claims determination is made, a beneficiary is notified and informed of the option to appeal. We do not believe that it is appropriate to set up what amounts to a second appeals process to be invoked in cases where a patient subsequently decides that there may be a financial advantage in appealing a prior claim.

8. General

Comment: One commenter noted that it is unfair to base a presumption about the care rendered during the 60 days prior to a hospital admission on a claims determination that may have occurred during a prior period.

Response: We intend to base the presumptions only on claims determinations that apply to the 60-day period immediately preceeding a hospital admission. We will only permit presumptions to be based on determinations that relate to the days of inpatient care in question. Where there is no claims determination, the presumption in 42 CFR 409.60(c)(2)(iii) would be applied.

9. Retroactivity

Comment: One commenter recommended that the regulations be made retroactive to the date when these procedures were implemented in some parts of the country as a result of litigation; that is, January 1, 1985.

Response: We believe that prospective implementation of these rules is an appropriate resolution of the issue. A retroactive effective date would pose extraordinary administrative problems for the program. In addition, such an action would disadvantage all those beneficiaries who would have begun new benefit periods under the new procedures and would therefore be liable for paying Medicare deductible amounts for which they were not liable under existing procedures.

10. Presumptions—Linkage With Medicaid

Comment: One commenter suggested that the linkage with Medicaid claims determinations is inappropriate both because of the administrative burden of establishing the necessary relationships and because Medicaid coverage requirements for SNF care are different from Medicare requirements.

Response: We do not agree. Linkage between the Medicare and Medicaid programs has always been advantageous to both programs and we believe it should be encouraged. We would also note that Medicare and Medicaid SNF coverage requirements are intended to be the same. The clear meaning of the Senate Finance Committee Report that accompanied the Social Security Amendments of 1972 was that both programs should have the same SNF level of care standards. To the extent that there are variations between the programs, we hope that these regulations will help remove them.

Comment: We have learned that in at least one State (New York), the Medicaid program is required by law to continue payment to SNFs in cases where the patient no longer requires a SNF level of care. Payment is continued at a lower rate. We have been asked to explain how these Medicaid payments would relate to the presumptions we have established that rely on Medicaid payment determinations.

Response: The payment presumptions relate exclusively to payment to SNFs for SNF care. In a case where a SNF was being paid for a lower level of care there would be no presumption that skilled care was rendered. In such cases, we would expect the intermediary to base its determinations on the actual level of care needed and received and not on the fact that a payment was made.

11. Presumptions—Implementation

Comment: One commenter asserted that it would be difficult for Medicare intermediaries to implement the presumptions and raised a number of issues relating to implementing them. It was suggested that Medicare intermediaries be provided with additional guidance.

Response: Intermediaries serving 14 States and 2 territories have been applying these presumptions since January 1, 1985. They have done so based on instructions contained in sections 3035, 3619.5, 3620, 3670, 3719.1, and 3722 of the Medicare Intermediary Manual (HCFA Pub. 13–3, Transmittal 1171, December 1984). To date we have

received no complaints or requests for further instructions regarding the use of these presumptions; however, if we do receive requests for clarification, we will further revise these instructions.

We agree with the commenter that intermediaries who are unable easily to obtain the claims information necessary to apply these presumptions should have the option to substitute a review of the patient's care during the 60 days prior to a hospital admission. For example, the intermediary may find it difficult to obtain claims information from a State Medicaid agency or from the intermediary which processed a SNF claim for the period in question. We are therefore revising the language of the regulation to provide this option for the intermediaries. We would note that we have developed these presumptions to help intermediaries make claims determinations on these issues efficiently. We did not intend them to prevent the use of more efficient methods in cases where these are available.

B. Drug Regimen Reviews in SNFs and ICFs

We received nearly 100 comments on our proposal, all opposed to it. The proposal provided that either a registered nurse or a pharmacist may perform drug regimen reviews in SNFs or ICFs. The major reasons for opposition were assertions that nurses are not equipped by their training and experience to perform drug regimen reviews and that they do not have sufficient time to perform them in the course of their duties. Most of the associations commenting also recommended that regulations be revised to require the use of a pharmacist to perform drug regimen reviews in ICFs.

We have reexamined the issue in the light of the comments and have decided to leave in place the current SNF requirement that a pharmacist perform these reviews. We are also deleting both the current and the proposed ICF requirements and substituting, as recommended by the commenters, a requirement that drug regimen reviews be performed by pharmacists. We are making these changes because the commenters have persuaded us that the proper conduct of these reviews can best be assured by requiring that a pharmacist perform them.

V. Summary of Changes

Based on the comments received, we are making the following changes to the proposed rule.

A. Benefit Period Determination

1. We have amended the language of presumption 1 contained at § 409.60(c)(1)(i) to provide for those cases in which the same SNF stay may be subjected to conflicting Medicare and Medicaid claims determinations.

2. We have added a subparagraph (c)(3) with respect to presumptions to provide that if information upon which to base a presumption is not readily available to the intermediary, the intermediary may review the beneficiary's medical records to determine whether he or she was an inpatient of a SNF as set forth under paragraph (b)(2) of this section.

3. We have amended regulations to make reference to skilled nursing care furnished by a SNF described in section 1861(y) of the Act (Christian Science Sanitoria).

B. Drug Regimen Reviews

We have deleted our proposed change to § 405.1127 regarding allowing a registered nurse to perform drug regimen reviews in SNFs. We have also altered the ICF proposal at § 442.336 to require that a pharmacist must review medications.

C. Minor Technical Corrections

We have made minor technical corrections to correct typographical errors in the proposed rule.

VI. Regulatory Impact Statement

A. Introduction

Executive Order 12291 (E.O. 12291) requires us to prepare and publish a regulatory impact analysis for any major rule. A major rule includes any proposed regulation that would have an annual effect on the economy of $100 million or more; cause a major increase in costs or prices for consumers, individual industries, Federal, State, or local government agencies, or geographic regions; significant adverse effects on competition, employment, investment, productivity, innovation, or on the ability of United States-based enterprises to compete with foreign-based enterprises in domestic or export markets. In addition, consistent with the Regulatory Flexibility Act (RFA) (5 U.S.C. 601 through 612) we also prepare and publish an initial regulatory flexibility analysis for any proposed regulation that would have a significant impact on a substantial number of small entities. For purposes of the RFA, we consider all providers to be small entities.

The changes on drug regimen reviews and the other technical changes will not have a significant effect on Medicare or Medicaid program expenditures or on State or provider operations. We base this view primarily on anecdotal evidence gained from State surveyors that many ICFs currently use pharmacists to perform these reviews in recognition of the need for that level of skill. If this is true, our change should not have a large impact. However, our proposals on benefit period determinations will have some significant effects. Although we do not believe that those effects will be of such a magnitude as to require either a regulatory impact analysis or a regulatory flexibility analysis, we have provided the following discussion of the expected impact of this regulation in order to clarify our reasons for not preparing analyses under either E.O. 12291 or the RFA.

B. Benefit Period Determinations

As noted above in this preamble, for benefit period determinations a beneficiary's care in a SNF must meet certain skilled level of care requirements in order for the beneficiary to be considered an "inpatient" of the SNF. We anticipate that implementation of this regulation on a nation-wide basis could generate certain costs and savings to the Medicare and Medicaid programs, improvements in the administration of State long-term care programs, and advantages and disadvantages to some beneficiaries.

1. Budget Impact

We estimate a final net annual budget increase of $10 million in combined program expenditures. This impact reflects increased Medicare net costs offset by Medicaid savings, as follows:

[In million of dollars]

Medicare cost	Medicare savings	Net Medicare cost	Medicaid savings	Final net cost
$50	−$35	$15	−$5	$10

The Medicare costs represent an expected increase in benefit payments resulting from new benefit periods while the Medicare savings reflect expenditures made unnecessary by payment of new hospital deductibles generated by those beneficiaries beginning new benefit periods under these regulations. Medicaid savings will result from Medicare payment for services currently paid for by Medicaid for certain dually eligible beneficiaries. Thus, the net budget impact represents an increase in Medicare program expenditures to implement this change in our benefit period policies to

accommodate the dictates of several Federal court decisions.

2. Beneficiary Impact

In practice, this regulation will affect different beneficiaries differently, depending on the specific circumstances of each beneficiary's situation. The regulation will make it easier for a beneficiary to end a benefit period and thereby begin a new one. For a beneficiary who has used enough inpatient hospital or SNF care to now be using coinsurance days, lifetime reserve days or be in "days exhausted" status, it will be beneficial to end one period and begin a new one. As a result of this regulation, these beneficiaries could start a new benefit period if they reside in a SNF. This would generate more payment liability for the Medicare program and reduce the beneficiary's liability because the beneficiary would not continue to pay coinsurance or, in benefits exhausted cases, the full charges amount.

On the other hand, the regulation will not be advantageous for a beneficiary who has not made extensive use of the inpatient hospital benefit. Such a beneficiary usually will have paid his or her required deductible when beginning the benefit period. As long as the beneficiary is in Medicare full payment days (that is, before coinsurance days are triggered by utilization) it is to his or her advantage to have the current benefit period prolonged until the full-pay days are exhausted. Thus, the beneficiary would avoid paying another deductible for the full-pay Medicare days (that is, for covered care) to which the person is already entitled in becoming a hospital inpatient again. Beneficiaries in this latter category who "reside" in a SNF (that is, do not receive skilled care) will be required to pay new deductibles if they become hospitalized. Under existing rules (in those areas of the country not under a Mayburg-type court order discussed elsewhere in this document), those SNF stays would prolong a benefit period, and no deductible would be owed at the beginning of a new hospitalization.

3. Other Program Effects

We anticipate at least one other, less significant, outcome from the change to our current benefit period policy. By providing States with incentives to draw SNF and ICF level of care distinctions under their Medicaid programs more efficiently, we believe that level of care determinations for recipients will be made appropriately in a greater number of cases and that as a result, State payments to long term care facilities will more accurately reflect the range of health care resources consumed by the patients.

Under this rule, Medicare will presume (in the case of beneficiaries entitled both to Medicare and Medicaid) that skilled care was needed and received if a State makes a Medicaid SNF payment for the care. As a result of that presumption, if Medicaid SNF payments are made for a beneficiary in a SNF but who is not at the skilled level of care, the beneficiary is unable to end his Medicare benefit period. Thus, beneficiaries who are either in copay or exhausted status under the Medicare SNF or hospital inpatient benefit would receive either reduced or no Medicare payment for any inpatient SNF or hospital services needed subsequent to the non-skilled stay for which the State made Medicaid SNF payment, and Medicaid liability would continue.

The result is that for those beneficiaries who are also Medicaid-eligible, the State will become the liable payer for the cost of the services not paid for by Medicare. We believe that this regulation will create a fiscal incentive to States to assure that the distinction between SNF and ICF care is properly made. This improvement, over time should lead to more accurate SNF and ICF payment rates and more appropriate use of nursing home beds.

4. Effect of Medicare Catastrophic Insurance Enactment

The Secretary is currently proposing legislation that would alter the Medicare program to provide catastrophic insurance for Medicare patients. One aspect of that proposal would restructure the basic Medicare Part A coverage scheme to eliminate the benefit period or "spell of illness" concept and replace it with other measures of eligibility for inpatient hospital and SNF care. In the event the proposal is enacted, the cost and savings associated with this final regulation would not be realized.

C. Summary

In summary, we have determined, and the Secretary certifies, that this final regulation will not result in a significant economic impact on a substantial number of small entities. In addition, the estimated impact would not meet the $100 million threshold or the other criteria for identifying major rules under Executive Order 12291. Because this final regulation will not result in an annual economic impact that meets the threshold criteria of Executive Order 12291 or of the RFA, we have not prepared either a regulatory impact analysis or a regulatory flexibility analysis.

Finally, section 9321(d) of Pub. L. 99-509 specifies that we may not issue any final rule or notice, between October 21, 1986 and September 1, 1987, that would result in a $50 million or greater reduction in payments to hospitals or physicians for FY 1988. This final regulation would not result in a $50 million or greater reduction in payments to hospitals or physicians for FY 1988. Therefore, we may issue the regulations in compliance with section 9321(d) of Pub. L. 99-509.

D. Paperwork Reduction Act 1980

This final rule regarding benefit period determinations and drug regimen reviews does not impose any additional information collection requirements. Consequently, they need not be reviewed by the Executive Office of Management and Budget (EOMB) under the Authority of the Paperwork Reduction Act of 1980 (44 U.S.C. 3501 *et seq.*).

List of Subjects

42 CFR Part 405

Administrative practice and procedure, Health facilities, Health professions, Kidney diseases, Laboratories, Medicare, Nursing homes, Reporting and recordkeeping requirements, Rural areas, X-rays.

42 CFR Part 409

Health facilities, Medicare.

42 CFR Part 442

Grant programs—health, Health facilities, Health professions, Health records, Medicaid, Nursing homes, Nutrition, Reporting and recordkeeping requirements, Safety.

PART 405—FEDERAL HEALTH INSURANCE FOR THE AGED AND DISABLED

A. 42 CFR Part 405 is amended as set forth below:

Subpart G—[Amended]

1. The authority citation for Part 405, Subpart G is revised to read as follows:

Authority: Secs. 1102, 1154, 1155, 1869(b), 1871, 1872 and 1879 of the Social Security Act (42 U.S.C. 1302, 1320c, 1395ff(b), 1395hh, 1395ii and 1395pp).

§ 405.702 [Amended]

2. In § 405.702, in the first and second sentences, the parenthetical references "(see § 405.401(c))" and "(see § 405.605)", respectively, are removed as outdated and unnecessary.

3. In § 405.704, the introductory language to paragraph (b) is reprinted and (b)(10) is revised to read as follows:

§ 405.704 Actions which are initial determinations

* * * * *

(b) Requests for payment by or on behalf of individuals. An initial determination with respect to an individual includes any determination made on the basis of a request for payment by or on behalf of the individual under Part A of Medicare, including a determination with respect to: * * *

(10) The beginning and ending of a spell of illness, including a determination made under the presumptions established under § 409.60(c)(2) of this chapter, as specified in § 409.60(c)(4) of this chapter

* * * * *

Subpart K—[Amended]

4. The authority citation for Part 405, Subpart K is revised to read as follows:

Authority: Secs. 1102, 1814, 1832, 1833, 1861, 1863, 1865, 1866, 1871, of the Social Security Act; 42 U.S.C. 1302, 1395f, 1395k, 1395l, 1395x, 1395z, 1395bb, 1395cc, 1395hh.

PART 409—MEDICARE BENEFITS, LIMITATIONS, AND EXCLUSIONS

B. 42 CFR Part 409 is amended as set forth below:

1. The authority citation for Part 409 is revised to read as follows:

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).

2. Section 409.60 is revised to read as follows:

§ 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 hospital or SNF services after he or she has ended a benefit period as described in paragraph (b) of this section.

(b) *When benefit periods end.* (1) A benefit period ends when a beneficiary has, for at least 60 consecutive calendar days, not been an inpatient in any hospital that meets the requirements of section 1861(e)(1) of the Act or in any SNF that meets the requirements of section 1861(j)(1) or 1861(y) of the Act.

(2) For purposes of ending a benefit period, a beneficiary was an inpatient of a SNF if his or her care in the SNF met the skilled level of care requirements specified in § 409.31(b) (1) and (3).

(c) Presumptions. (1) For purposes of determining whether a beneficiary was an inpatient of a SNF under paragraph (b)(2) of this section—

(f) A beneficiary's care met the skilled level of care requirements if inpatient SNF claims were paid for those services under Medicare or Medicaid, unless:

(A) Such payments were made under § 405.330 or Medicaid administratively necessary days provisions which result in payment for care not meeting the skilled level of care requirements, or

(B) A Medicare denial and a Medicaid payment are made for the same period, in which case the presumption in paragraph (c)(2)(ii) of this section applies;

(ii) A beneficiary's care met the skilled level of care requirements if a SNF claim was paid under section 1879(e) of the Social Security Act;

(iii)A beneficiary's care did not meet the skilled level of care requirements if a SNF claim was paid for the services under § 405.330;

(iv) A beneficiary's care did not meet the skilled level of care requirements if a Medicaid SNF claim was denied on the grounds that the services were not at the skilled level of care (even if paid under applicable Medicaid administratively necessary days provisions which result in payment for care not meeting the skilled level of care requirements);

(2) For purposes of determining whether a beneficiary was an inpatient of a SNF under paragraph (b)(2) of this section a beneficiary's care in a SNF is presumed—

(i) To have met the skilled level of care requirements if a Medicaid or Medicare claim was denied on grounds other than that the services were not at the skilled level of care;

(ii) Not to have met the skilled level of care requirements if a Medicare SNF claim was denied on the grounds that the services were not at the skilled level of care and payment was not made under § 405.330; or

(iii) Not to have met the skilled level of care requirements if no Medicare or Medicaid claim was submitted by the SNF.

(3) If information upon which to base a presumption is not readily available, the intermediary may, at its discretion review the beneficiary's medical records to determine whether he or she was an inpatient of a SNF as set forth under paragraph (b)(2) of this section.

(4) When the intermediary makes a benefit period determination based upon paragraph (c)(1) of this section, the beneficiary may seek to reverse the benefit period determination by timely appealing the prior Medicare SNF claim determination under 42 CFR Part 405, Subpart G, or the prior Medicaid SNF claim under 42 CFR Part 431, Subpart E.

(5) When the intermediary makes a benefit period determination under paragraph (c)(2) of this section, the beneficiary will be notified of the basis for the determination, and of his or her right to present evidence to rebut the determination that the skilled level of care requirements specified in § 409.31 (b)(1) and (b)(3) were or were not met on reconsideration and appeal under 42 CFR, Part 405, Subpart G.

(d) *Limitation on benefit period determinations.* When the intermediary considers the same prior SNF stay of a particular beneficiary in making benefit period determinations for more than one inpatient Medicare claim—

(1) Medicare will recognize only the initial level of care characterization for that prior SNF stay (or if appealed under 42 CFR Part 405, Subpart G, the level of care determined under appeal); or

(2) If part of a prior SNF stay has one level of care characterization and another part has another level of care characterization, Medicare will recognize only the initial level of care characterization for a particular part of a prior SNF stay (or if appealed under 42 CFR Part 405, Subpart G, the level of care determined under appeal).

(e) *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 Subpart G of this part apply for each benefit period. The limitations of § 409.63 apply only to the initial benefit period.

PART 442—STANDARDS FOR PAYMENTS FOR SKILLED NURSING AND INTERMEDIATE CARE FACILITY SERVICES

C. 42 CFR Part 442 is amended as set forth below:

1. The authority citation for Part 442 continues to read as follows:

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302), unless otherwise noted.

2. Section 442.336(a) is amended by adding a reference to a pharmacist and deleting reference to a registered nurse. As revised, paragraph (a) reads as follows:

§ 442.336 Review of medications.

(a) A pharmacist must review medications monthly for each resident and notify the physician if changes are appropriate.

* * * * *

Catalog of Federal Domestic Assistance Program No. 13.774, Medicare—Supplementary Medical Insurance Program; No. 13.714, Medical Assistance Program)

Dated: March 11, 1987.

William L. Roper,

Administrator, Health Care Financing Administration.

Approved: May 11, 1987.

Don M. Newman,

Acting Secretary.

[FR Doc. 87-13449 Filed 6-12-87; 8:45 am]

BILLING CODE 4120-01-M

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

43 CFR Part 3100

[AA-620-4111-02-24-10]

Clarification of Provision of Bureau of Land Management; "State, Nationwide, or National Petroleum Reserve in Alaska Oil and Gas Bond", Form 3104-8

AGENCY: Bureau of Land Management, Interior.

ACTION: Clarification of the meaning of certain provisions of the Bureau of Land Management's State and Nationwide Oil and Gas Bond Form 3104-8.

SUMMARY: In the terms and conditions of the Bureau of Land Management's (BLM) State and Nationwide Bond Form 3104-8, there is a provision that is being misinterpreted by some surety companies to mean that, with a 30-day Notice to BLM, they can cease bond coverage on leases extended beyond their primary term. This notice clarifies that this is not permissible.

EFFECTIVE DATE: June 15, 1987.

ADDRESS: Inquiries or suggestions should be sent to: Director (620), Bureau of Land Management, 18th & C Streets, NW., Washington, DC 20240.

FOR FURTHER INFORMATION CONTACT: Gloria J. Austin, Bureau of Land Management, (202) 653-2190.

SUPPLEMENTARY INFORMATION: On the reverse side of the subject bond form 3104-8 is a proviso that reads: "Provided, that the surety may elect to have the additional coverage authorized under this paragraph become inapplicable as to all interests of the principal acquired more than thirty (30) days after the receipt of notice of such election by the Bureau of Land Management."

In the paragraph referred to by this wording there are references to "Any oil and gas lease hereafter issued to or acquired by the principal * * *;" "Any operating agreement hereafter entered into or acquired by the principal * * *;" and "Any designation subsequent hereto of the principal as operator * * *." It is these additional coverages acquired after the bond agreement has been entered into that are the subject of the provision allowing the surety after 30 days notice to BLM to elect to become inapplicable. In each case through the words "hereafter" and "subsequent hereto" it is made clear that such acquisitions postdate the bond agreement and therefore, as a matter of equity to the surety, are electable as inapplicable.

Also included in the same paragraph, however, is reference to extensions of leases already covered by the bond agreement which by their nature are not additional acquisitions but rather a continuation of existing obligations. Extensions, as set out by the statute at 30 U.S.C. 187, 209, and 226, are interests contemplated in the lease itself, and are contingent interests which vest if the lessee fulfills contingency requirements in the lease. Extensions, therefore, are not among the additional coverages noted in the paragraph as being acquired after or subsequent to the bond agreement and, as such, are not subject to the "inapplicability" provision.

Nonetheless, because of the construction of the paragraph that ties the paragraph to preceding sections covering authorizations and obligations, some surety companies have mistakenly lumped extensions with additional acquisitions subject to the provision allowing them to elect inapplicability of the additional acquisitions. It is not now, and never has been in the 20 years this provision has been in effect, a proper reading of the bond form to so construe lease extensions or the provisions on inapplicability.

Dated: June 3, 1987.

David O'Neal,

Deputy Director, Bureau of Land Management.

[FR Doc. 87-13557 Filed 6-12-87; 8:45 am]

BILLING CODE 4310-84-M

COMMISSION ON THE BICENTENNIAL OF THE UNITED STATES CONSTITUTION

45 CFR Part 2001

Project Recognition and Use of Logo; Defense Communities

AGENCY: Commission on the Bicentennial of the United States Constitution.

ACTION: Interim rule with request for comments.

SUMMARY: This interim rule amends 45 CFR Part 2001 by adding § 2001.38 *Bicentennial Defense Communities* to Subpart C—*Involvement with Bicentennial Projects.* The effect of this action is to permit the Commission to officially recognize defense installations (Army, Navy, Air Force, Marines and Coast Guard) for their community efforts here and overseas to honor and commemorate the United States Constitution.

DATES: This interim rule is effective January 24, 1987; public comments thereon must be received before July 31, 1987.

ADDRESS: Comments may be mailed or delivered to the Office of General Counsel, Commission on the Bicentennial of the United States Constitution, 736 Jackson Place NW., Washington, DC 20503.

FOR FURTHER INFORMATION CONTACT: Joseph B. McGrath, General Counsel, Tel. (202) 275-9178.

SUPPLEMENTARY INFORMATION:

Background

Subpart C of 45 CFR Part 2001, the regulations governing the Commission's involvement in bicentennial projects sponsored by other organizations, was published as part of a final rule on October 15, 1986 (51 FR 36786-36794).

This additional amendment to the Commission's regulations will assist State Bicentennial Commissions and the Defense Department's bicentennial programs. It will expedite and expand opportunities for defense installations to achieve recognition for their programs in honor of the Constitution. Prior to this amendment, defense installations were required to comply with the same application process as civil, political jurisdictions such as counties, cities, towns, etc., including review by State Bicentennial Commissions.

In a far reaching effort, the Defense Department has invited all installation commanders to consider becoming Bicentennial Communities. This amendment to the Commission regulations will assist in this process and benefit all of the communities of servicemen and women who constitute the cohesive communities of defense installations.

Amendments

A new § 2001.38 has been added to authorize official recognition for defense communities, with definitions, qualification criteria, application