xiv. Other wastewater treatment

48WT Wet air oxidation
49WT Neutralization
50WT Other wastewater treatment
51WT Primary wastewater treatment system
52WT Secondary wastewater treatment system
53WT Tertiary wastewater treatment system

(h) Treatment of air emissions

1AT Thermal oxidizer
2AT Catalytic incineration
3AT Flare
4AT Condenser
5AT Scrubbers
6AT Absorbers
7AT Filters
8AT Electrostatic Precipitations
9AT Carbon adsorption
10AT Other adsorption
11AT Mechanical separation
12AT Other air emission control

NOTES:

1. Chemical precipitation is a treatment operation whereby the pH of a waste is adjusted to the range necessary for removal (precipitation) of contaminants. For purposes of this reporting flocculation and settling are considered part of the system. NOTE: if the pH is adjusted solely to achieve a neutral pH, THE OPERATION IS NEUTRALIZATION.

2. As a treatment operation, steam stripping is the removal of organic contaminants from a waste using direct or indirect contact steam for the primary purpose of complying with publicly owned treatment works (POTW) or National Pollutant Discharge Elimination System (NPDES) wastewater discharge limitations.

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June 4, 1987

Part III

Department of the Interior

Minerals Management Service

Proposed 1989 Lease Sales in the Gulf of Mexico OCS Region; Call for Information and Nominations and Notice of Intent To Prepare an Environmental Impact Statement; Notice

4310-MR

UNITED STATES
DEPARTMENT OF THE INTERIOR
MINERALS MANAGEMENT SERVICE
Proposed 1989 Lease Sales in the
Gulf of Mexico OCS Region
Call for Information and Nominations
and
Notice of Intent to Prepare an Environmental Impact Statement

CALL FOR INFORMATION AND NOMINATIONS

Purpose of Call

The purpose of the Call is to assist the Secretary of the Interior in carrying out his responsibilities under the Outer Continental Shelf Lands Act (OCSLA) (43 U.S.C. 1331-1343), as amended, and regulations appearing at 30 CFR 256.23 with regard to proposed OCS Lease Sales 118 and 122, tentatively scheduled for March 1989 and August 1989, in the Central and Western Gulf of Mexico, respectively. The proposed lease sales are identified in the Proposed Final 5-Year Outer Continental Shelf Oil and Gas Leasing Program for Mid-1987 through Mid-1992, dated April 1987.

This initial information-gathering step is important for ensuring that all interests and concerns are communicated to the Department of the Interior (DOI) for future decision points in the leasing process. It should be recognized that this Notice does not indicate a preliminary decision to lease in the areas described below.

Information submitted in response to this Call will be used for several purposes. First, responses will be used to identify the areas of potential for oil and gas development. Second, comments on possible environmental effects and use conflicts will be used in the analysis of environmental conditions in and near the Call area. Together these two considerations will allow a preliminary determination of the potential advantages and disadvantages of oil and gas exploration and development to the region and the Nation. Thus, it may be possible to make key decisions in connection with the next step in the planning process--Area Identification--to resolve conflicts by deleting areas where there is sufficient information to justify that action. However, the Area Identification represents only a preliminary step to select the area to be analyzed in the environmental impact statement (EIS). The Area Identification is scheduled for August 1987.

A third purpose for this Notice is to use the comments collected to initiate scoping of the EIS, which will include public meetings, and to identify and analyze alternatives to the proposed action. A Notice of Intent (NOI) to Prepare an EIS which covers scoping is located later in this document. Fourth, comments may be used in developing lease terms and conditions to assure safe offshore operations. Fifth, comments may be used in understanding and considering ways to avoid or mitigate potential conflicts between offshore oil and gas activities and the Gulf Coast States' Coastal Management Programs (CMP's).

Description of Area

The general area of this Call covers the entire central and western portions of the Gulf of Mexico between approximately 88° W. longitude on the east and approximately 97° W. longitude on the west and extends from the Federal-State boundaries seaward to the provisional maritime boundary between the United States and Mexico. The entire Call area is offshore the States of Texas, Louisiana, Mississippi, and Alabama. This area is divided into two planning areas for individual 1989 lease sales in the Central and Western Gulf of Mexico.

The Central Gulf of Mexico (CGOM) planning area is bounded on the east by approximately 88° W. longitude. Its western boundary begins at the offshore boundary between Texas and Louisiana and proceeds southeasterly to approximately 28° N. latitude, thence east to approximately 92° W. longitude, thence south to the provisional maritime boundary with Mexico which constitutes the southern boundary of the area. The northern part of the area is bounded by the Federal-State boundary offshore Louisiana, Mississippi, and Alabama.

The Western Gulf of Mexico (WGOM) planning area is bounded on the west and north by the Federal-State boundary and on the east by the Central Gulf of Mexico planning area. The area extends south to the provisional maritime boundary with Mexico.

The following list comprises the Leasing Maps and the OCS Official Protraction Diagrams used in identifying this Call area. These maps and diagrams may be purchased from the Public Information Unit, Gulf of Mexico OCS Region, at the address stated below under "Instructions on Call."

1. Central Gulf of Mexico (CGOM)

Leasing Maps

Outer Continental Shelf Leasing Maps - Louisiana Nos. 1 through 12.

This set of 27 maps sells for $17.00.

Outer Continental Shelf Official Protraction Diagrams

These diagrams sell for $2.00 each.

		Date of Issue
NH 15-12	Ewing Bank	December 2, 1976
NH 16-4	Mobile	April 19, 1983
NH 16-7	Viosca Knoll	December 2, 1976
NH 16-10	Mississippi Canyon	December 2, 1976
NG 15-3	Green Canyon	December 2, 1976
NG 15-6	Walker Ridge	December 2, 1976
NG 15-9	(No Name)	March 3, 1987
NG 16-1	Atwater Valley	November 10, 1983
NG 16-4	(No Name)	December 2, 1976
NG 16-7	(No Name)	March 3, 1987

2. Western Gulf of Mexico (WGOM)

Leasing Maps

Outer Continental Shelf Leasing Maps - South Texas Nos. 1 through 4, with Map 1A revised as of December 16, 1985.

This set of seven maps sells for $5.00

Outer Continental Shelf Leasing Maps - East Texas Nos. 5 through 8. This set of nine maps sells for $7.00.

Outer Continental Shelf Official Protraction Diagrams

These diagrams sell for $2.00 each.

		Date of Issue
NG 14-3	Corpus Christi	January 27, 1976
NG 14-6	Port Isabel	December 16, 1985
NG 15-1	East Breaks	January 27, 1976
NG 15-2	Garden Banks	December 2, 1976
NG 15-4	Alaminos Canyon	December 16, 1985
NG 15-5	Keathley Canyon	March 3, 1987
NG 15-8	(No Name)	March 3, 1987

Areas Deferred from this Call

1. High Island Area, East Addition, South Extension, dated October 19, 1981, (Flower Gardens), Block A-375 and Block A-398 (WGOM).

Instructions on Call

A standard Call for Information Map specific to this event delineates the Call area and shows the area identified by the Minerals Management Service (MMS) as having potential for the discovery of accumulations of oil and gas. Respondents are requested to indicate interest in and comment on any or all of the Federal acreage within the boundaries of the Call area that they wish to have included in proposed OCS Lease Sales 118 and 122. Boundaries of the Call area are shown on the standard Call for Information Map available free from the Public Information Unit, Gulf of Mexico OCS Region, Minerals Management Service, 1201 Elmwood Park Boulevard, New Orleans, Louisiana 70123-2394, telephone (504) 736-2519. Although individual indications of interest are considered to be privileged and proprietary information, the names of persons or entities indicating interest or submitting comments will be of public record. Those indicating such interest are required to do so on the standard Call for Information Map. Interest should be shown by outlining the areas of interest along block lines.

Respondents may submit a detailed list of whole and partial blocks nominated (by OCS Leasing Map numbers and Official Protraction Diagram designations) to ensure correct interpretation of their nominations. The telephone number and name of a person to contact in the respondent's organization for additional information should be included.

Respondents should rank areas in which they have expressed interest according to priority of their interest (e.g., priority 1 (high), 2 (medium), or 3 (low)). We encourage respondents to be specific in listing blocks by priority. The information is very helpful in assessing the area to be identified for further study at future sale decision points. Blanket nominations on large areas are not as useful in providing information pertinent to analysis of industry interest. Areas where interest has been indicated but which have no specified priorities will be considered priority 3. Information concerning both location and priority of interest submitted by individual respondents will be held proprietary and confidential and will help determine the area upon which the EIS analysis will be focused. In addition to indications of interest by respondents, further consideration of areas for analysis in the EIS will be based on hydrocarbon potential and environmental, economic, and multiple-use (including military use) conditions.

Comments are sought from all interested parties about particular geological, environmental, biological, archaeological, socioeconomic conditions, conflicts, or other information which might bear upon the potential leasing and development of particular areas. Comments are also sought on possible conflicts between future OCS oil and gas activities that may result from the proposed sales and State CMP's. If possible, these comments should identify specific CMP policies of concern, the nature of the conflict foreseen, and steps that the MMS could take to avoid or mitigate the potential conflict. Comments may either be in the terms of broad areas or restricted to particular blocks of concern. Those submitting comments are requested to outline the subject area on the standard Call for Information Map.

Indications of interest and comments must be received no later than 45 days following publication of this document in the Federal Register in envelopes labeled "Nominations for Proposed 1989 Lease Sales in the Gulf of Mexico" or "Comments on the Call for Information and Nominations for Proposed 1989 Lease Sales in the Gulf of Mexico."

The standard Call for Information Map and indications of interest and/or comments must be submitted to the Regional Supervisor, Leasing and Environment, Gulf of Mexico OCS Region, at the address stated above under "Instructions on Call."

Tentative Schedule

Final delineation of the areas for possible leasing will be made at a later date only after compliance with established Departmental procedures, all requirements of the National Environmental Policy Act of 1969 (42 U.S.C. 4321-4347), and the OCSLA, as amended. A final Notice of Sale for each sale held will be published in the Federal Register detailing areas to be offered for competitive bidding, stating the terms and conditions for leasing, and announcing the location, date, and time bids will be received and opened.

Tentative milestones for these sales are as follows:

	CGOM Sale 118	WGOM Sale 122
Comments due on the Call	July 1987	July 1987
NOI Comments Due (Scoping)	July 1987	July 1987
Area Identification	August 1987	August 1987
Draft EIS published	March 1988	March 1988
Hearings held on Draft EIS	April 1988	April 1988
Final EIS published	August 1988	August 1988
Proposed Notice of Sale announced	September 1988	February 1989
Governor's comments due on Proposed Notice	November 1988	April 1989
Final Notice of Sale published	January 1989	June 1989
Sale Date	March 1989	August 1989

Existing Information

Information already available includes that previously gathered during the EIS process for the Proposed Final 5-Year Oil and Gas Leasing Program. In addition, comments previously received by the DOI from State and local governments, other Federal Agencies, environmental groups, and the oil and gas industry concerning past OCS actions will be used. The following is a list of other information which will be available to the DOI for consideration regarding the proposed 1989 OCS Lease Sales in the Gulf of Mexico.

Gulf of Mexico Indices and Summary Reports

1. Gulf of Mexico Index, December 1980 through August 1982, prepared for MMS.
2. Gulf of Mexico Index, September 1982 through July 1983, prepared for MMS.
3. Gulf of Mexico Summary Reports, 1983 through 1986, prepared for MMS.

Environmental Studies Program Information in the Central and Western Gulf of Mexico

The DOI initiated studies in these areas in 1973. The emphasis, including continuing studies, has been on geological mapping, environmental characterization of biologically sensitive habitats, physical oceanography, ocean circulation modeling, and ecological effects of oil and gas activities. These studies will provide useful information for a number of environmental issues including topographic features, deepwater biological communities on the continental slope, and coastal wetland habitats.

A complete listing of available study reports and information for ordering copies can be obtained from the Gulf of Mexico Regional Office at the address stated under "Instructions on Call," or by telephone at (504) 736-2519, Public Information Unit. The reports may also be ordered for a fee directly from the National Technical Information Service by calling (703) 487-4650. The mailing address is U.S. Department of Commerce, National Technical Information Service, 5285 Port Royal Road, Springfield, Virginia 22161.

In addition, a program status report for continuing studies in this area can be obtained from the Chief, Environmental Studies Section, Gulf of Mexico Regional Office at the address stated under "Instructions on Call" or by telephone at (504) 736-2896.

NOTICE OF INTENT TO PREPARE AN ENVIRONMENTAL IMPACT STATEMENT

Purpose of Notice of Intent

Pursuant to the regulation (40 CFR 1501.7) implementing the procedural provision of the National Environmental Policy Act of 1969 (42 U.S.C. 4321-4347), the MMS is announcing its intent to prepare an EIS regarding the oil and gas leasing proposals known as Sale 118 in the Central Gulf of Mexico and Sale 122 in the Western Gulf of Mexico. The Notice of Intent also serves to announce the scoping process which will be followed for the EIS. The scoping process is intended to involve Federal, State, and local governments and other interested parties in aiding the MMS in determining the significant issues and alternatives to be analyzed in the EIS.

The MMS is considering the possibility of also addressing in this same EIS the two 1990 Central and Western Gulf of Mexico sales (Sales 123 and 125). Such a 2-year EIS, if considered feasible, would be followed at a later date by an Environmental Assessment for the 1990 sales and whatever additional actions would be deemed necessary and appropriate.

The EIS analysis will focus on the potential environmental effects of leasing, exploration, and development of the blocks included in the areas defined in the Area Identification procedure as the proposed areas of the Federal actions. Alternatives to the proposal which may be considered for each sale are to delay the sale, cancel the sale, or modify the sale.

Instructions on Notice of Intent

Federal, State, and local governments and other interested parties are requested to send their written comments on the scope of the EIS, significant issues which should be addressed, and alternatives which should be considered, to the Regional Supervisor, Leasing and Environment, Gulf of Mexico OCS Region, at the address stated under "Instructions on Call" above. Comments should be enclosed in an envelope labeled "Comments on the Notice of Intent to Prepare EIS on the Proposed 1989 Lease Sales in the Gulf of Mexico." Comments are due no later than 45 days from the publication of this Notice. Also, scoping meetings may be held in appropriate locations for the purpose of obtaining additional comments and information regarding the scope of the EIS. The times and locations of these scoping meetings will be announced at a future date in the Federal Register and by press release.

Acting Director, Minerals Management Service

David W. Crow

Approved:

Assistant Secretary - Land and Minerals Management

J. Steven Griles

MAY 29 1987

Date

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Thursday
June 4, 1987

Part IV

Department of Health and Human Services

Health Care Financing Administration

42 CFR Part 405

Medicare Program; Changes to the Return on Equity Capital Provisions and the Exemption From Cost Limits for Newly-Established Home Health Agencies; Final Rule With Comment Period

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Part 405

[BERC-325-FC]

Medicare Program; Changes to the Return on Equity Capital Provisions and the Exemption From Cost Limits for Newly Established Home Health Agencies

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

ACTION: Final Rule with comment period.

SUMMARY: We are revising the regulations used to compute Medicare payment to certain providers of covered health care services, as follows:

- The allowance for a return on equity capital, which currently applies to all proprietary health care providers, will apply only to proprietary hospitals and skilled nursing facilities. Further, the allowance is reduced for skilled nursing facilities and outpatient hospital services.
- The exception to the home health agency cost limits for new agencies is eliminated.

DATES: *Effective dates:* These regulations are effective July 6, 1987.

However, see section IV.A. of the preamble for a discussion of the applicability of specific provisions.

Comment period: As discussed in section IV.C. of the preamble, we are providing a comment period concerning the reduction of the return on equity payments for all proprietary providers other than hospitals and SNFs. Comments about this provision will be considered if we receive them at the appropriate address, as provided below, no later than 5:00 p.m. on August 3, 1987.

ADDRESS: Mail comments to the following address: Health Care Financing Administration, Department of Health and Human Services, Attention: BERC-325-FC, P.O. Box 26676, Baltimore, Maryland 21207.

If you prefer, you may deliver your comments to one of the following addresses:

Room 309-G, Hubert H. Humphrey Building, 200 Independence Avenue SW., Washington, DC, or

Room 132, East High Rise Building, 6325 Security Boulevard, Baltimore, Maryland.

In commenting, please refer to file code BERC-325-FC. Comments received timely will be available for public inspection as they are received, generally beginning approximately three weeks after publication of a document, in Room 309-G of the Department's offices at 200 Independence Ave., SW., Washington, DC, on Monday through Friday of each week from 8:30 a.m. to 5:00 p.m. (phone: 202-245-7890).

FOR FURTHER INFORMATION, CONTACT:

Anthony Coates, (301) 597-2886—Return on Equity Capital

Steve Kirsh, (301) 594-5403—Elimination of New HHA Exception.

SUPPLEMENTARY INFORMATION:

I. Return on Equity Capital

A. Background

Section 1861(v) of the Social Security Act (the Act) defines "reasonable cost" and provides that the necessary costs incurred by a provider (both direct and indirect) in the delivery of covered health care services are included in this definition. A return on equity capital is paid as an allowance in addition to the reasonable cost of covered services furnished to beneficiaries by proprietary providers.

Section 7 of the 1966 Amendments to the Social Security Act (Pub. L. 89-713), enacted November 2, 1966, added what is now section 1861(v)(1)(B) of the Act to require the Secretary to prescribe regulations that provide for the recognition of a reasonable return on equity capital for extended care services furnished to Medicare beneficiaries by proprietary facilities (skilled nursing facilities (SNFs)). The legislative history (112 *Cong. Rec.* 28,220 (1966) (Statement of Rep. Byrnes)) expressed congressional concern that a return on equity capital for SNFs was necessary for the following reasons:

- As a means of saving Medicare Part A (Hospital Insurance) trust funds, Congress wanted to encourage the transfer of hospital patients to SNFs when further hospitalization was no longer necessary.
- It was doubtful whether nonprofit organizations would be able to provide a sufficient number of beds to meet the needs of the aged.
- Private investors in SNF facilities should be guaranteed a fair return on the money that they put into the operation.

The conference committee report (H.R. Rep. No. 2317, 89th Cong., 2nd Sess. 3 (1966)) suggested that proprietary hospitals should be treated comparably to proprietary SNFs with respect to the return on equity capital provisions. In response to these congressional concerns, we published regulations at 42 CFR 405.429 on November 22, 1966 (31 FR 14816). (This section of the regulations was redesignated as 42 CFR 413.157 on September 30, 1986 (51 FR 34790)).

Under section 1861(v)(1)(B) of the Act, the Secretary determined that SNFs, the primary provider of extended care services, should receive an allowance for the net equity of the capital invested by private owners and that this return on equity capital provision should apply not only to proprietary SNFs but also to all other proprietary providers (which, at that time, encompassed hospitals and home health agencies (HHAs)). Subsequently, the Medicare program has recognized other proprietary health care entities (comprehensive outpatient rehabilitation facilities (CORFs), providers of outpatient physical therapy and speech pathology services (OPTs), independent organ procurement agencies (OPAs), histocompatability laboratories (Histo-Labs), and rural health clinics (RHCs)) to which the provisions in § 413.157 apply. (For purposes of the discussion below concerning return on equity, when we use the term "providers", it encompasses all of these proprietary entities that furnish health care services to beneficiaries under the Medicare program.)

Until recently, the annual rate of return, paid on this investment relative to all provider services furnished to Medicare beneficiaries, has been calculated by applying a percentage equal to one and one-half times the average (that is, 150 percent of the average) of the rates of interest on special issues of public debt obligations issued for purchase by the Federal Hospital Insurance (Medicare Part A) Trust Fund. This rate, as prescribed in § 413.157, was the *maximum* amount allowed for return on equity to SNFs under section 1861(v)(1)(B) of the Act.

Section 601(e) of the Social Security Amendments of 1983 (Pub. L. 98-21) amended section 1886 of the Act by adding section 1886(g)(2), which provided that, effective with cost reporting periods beginning on or after April 20, 1983 (the date of enactment of Pub. L. 98-21), the Secretary's return on equity capital provisions apply to inpatient hospital services but that the allowable return for those services be reduced from a percentage equal to 150 percent to 100 percent of the average of the rates of interest on special issues of public debt obligations issued for purchase by the Medicare Part A Trust Fund. It is noteworthy that, at that time, this was the only amendment to the Medicare provisions of the Social Security Act that ever explicitly addressed the payment of a return on equity capital for proprietary hospitals.

Congress, therefore, as of April 20, 1983 had specifically provided allowances for a return on equity capital to both proprietary hospitals and SNFs. In addition, we have the authority under section 1881(b)(2)(C) of the Act to provide an allowance for a return on equity capital to end-stage renal disease (ESRD) facilities. However, in establishing a prospective payment system for ESRD facilities in 1983 (48 FR 21254), we excluded an allowance for equity capital from the composite rates used in determining the ESRD prospective payment rates. We did so because the inclusion of a return in the rate base for ESRD facilities would weaken the incentives established through the prospective payment rates (48 FR 21261). These facilities are expected to earn a return on investment by reducing per treatment costs below their payment rates through management efficiencies.

B. Summary of the Return on Equity Provisions of the Proposed Rule

We published a proposed rule in the **Federal Register** on February 20, 1986 (51 FR 6139). In that document, we proposed the following changes:

- Elimination of the return on equity capital for proprietary providers other than hospitals and SNFs.
- Reduction of the rates of return on equity capital for SNFs and outpatient hospital services to the level that Congress mandated for inpatient hospital services in section 1886(g)(2) of the Act.

We stated in the proposed rule that payment rates are adequate to maintain the availability of services (other than hospital and SNF services) to Medicare beneficiaries. We also cited the report issued by the Department's Office of the Inspector General, recommending that we discontinue providing an allowance for a return on equity capital to providers other than hospitals and SNFs (Audit Control No. 09-32607, October 12, 1983).

We received 19 timely sets of comments raising several issues about these proposals. However, after the close of the comment period, as we discuss below, legislation was enacted that deals specifically with Medicare policy concerning return on equity capital. The legislation generally supports our proposal and therefore obviates the need to address most of the public comments. Those comments that dealt with aspects of our proposal that were not addressed in the legislation are discussed below.

C. Recent Legislation

On April 7, 1986, the President signed into law the Consolidated Omnibus Budget Reconciliation Act of 1985 (Pub. L. 99-272). Section 9107 of that law amended sections 1861(v)(1), 1886(a)(4), and 1886(g)(2) of the Act to provide for the following:

1. Inpatient Hospital Services

Section 9107(a) of Pub. L. 99-272 amended section 1886(g)(2) of the Act by mandating a phase-down (and eventual elimination) of payments for return on equity capital for inpatient hospital services commencing with cost reporting periods beginning on or after October 1, 1986. The current payment (as provided by section 1886(g)(2) of the Act as it was enacted in Pub. L. 98-21) is calculated at 100 percent of the average of the rates of interest on special issues of public debt obligations issued for purchase by the Medicare Part A Trust Fund. The statutory change is self-implementing, and the phase-out reduces the rate to the following percentages:

- 75 percent for cost reporting periods beginning during fiscal year (FY) 1987.
- 50 percent for cost reporting periods beginning during FY 1988.
- 25 percent for cost reporting periods beginning during FY 1989.
- Zero percent for cost reporting periods beginning on or after October 1, 1989.

Under section 9321(c) of Pub. L. 99-509, issuance of final rules dealing with capital-related costs for inpatient hospital services are precluded until September 1, 1987. Therefore, conforming changes to the regulations dealing with the phase-out of the return on equity capital for inpatient hospital services will be published on or after September 1, 1987.

2. Services Other Than Inpatient Hospital Services

Section 9107(b)(2) of Pub. L. 99-272 amended section 1861(v)(1)(B) of the Act to provide that, for cost reporting periods beginning on or after October 1, 1985, the rate of return for SNFs must be equal to the average of the rates of interest on obligations issued for purchase by the Medicare Part A Trust Fund. In addition, section 9107(b)(1) of Pub. L. 99-272 added section 1861(v)(1)(P) to the Act to provide that if payment for a return on equity capital is provided for by regulations for services other than inpatient hospital services, the rate of return to be recognized for determining the reasonable cost of services furnished in a cost reporting period, beginning on or after October 1, 1985, must be equal to the average of the rates of interest on special issues of public debt obligations issued for purchase by the Medicare Part A Trust Fund. This latter provision, however, *applies only if* the Secretary provides in regulations for the payment of a return on equity capital for costs other than inpatient hospital services. The Secretary is not required to do so except for SNFs. The net effect of these provisions is that a rate of return must be provided for SNFs equal to the average of rates of interest on public debt obligations issued for purchase by the Part A Trust Fund and that, if we provide an allowance for a return on equity capital for other providers, the rate must be equal to that average.

D. Provisions of this Final Rule

In this final rule, we are conforming the regulations (with the exception of the phase-out of payments for return on equity capital for inpatient hospital services) to the provisions enacted in Pub. L. 99-272 that pertain to program payment of a return on equity capital. Where the provisions were mandated, they have been specifically adopted. Where the statutory language granted the Secretary discretionary authority, we have exercised this authority as discussed below. We have also given careful consideration to the timely comments received from the public on the proposed rule and have analyzed the alternatives suggested in those comments. We have decided to implement our proposal and the applicable provisions of Pub. L. 99-272 in the following manner:

- *SNF services and Outpatient Hospital Services (§ 413.157(b)(3)).* For cost reporting periods beginning on or after October 1, 1985, program payment of a return on equity capital for SNF services and outpatient hospital services is reduced to equal the average of interest on special issues of public debt obligations issued for purchase by the Part A Trust Fund.

Although many commenters on our proposed rule opposed any rate reduction, this change is statutorily mandated for SNFs by section 1861(v)(1)(B) of the Act, as amended by section 9107(b) of Pub. L. 99-272, and is authorized for outpatient hospital services by section 1861(v)(1)(P) of the Act, as added by section 9107(b) of Pub. L. 99-272.

- *Services of all nonhospital and non-SNF proprietary providers or health care entities § 413.157(b)(4).*

—For cost reporting periods beginning on or after October 1, 1985, but before [30 days after publication], program payment of a return on equity capital for

services of all nonhospital and non-SNF proprietary providers is reduced to equal the average of interest on special issues of public debt obligations issued for purchase by the Part A Trust Fund.

This change conforms to the statutory mandate of section 1861(v)(1)(P) of the Act, as enacted by section 9107(b) of Pub. L. 99–272. This section provides that the rate of return on equity capital (other than for inpatient hospital services) must be equal to the average of the rates of interest on obligations issued for purchase by the Part A Trust Fund.

—For cost reporting periods beginning on or after July 6, 1987, program payment will no longer be made for a return on equity capital for services of nonhospital and non-SNF proprietary providers.

As previously noted, Pub. L. 98–21 marked the first time that amendments to the Medicare provisions of the Social Security Act had ever explicitly addressed the payment of a return on equity capital for proprietary hospitals (or for any provider other than extended care facilities, that is, SNFs). Under the broad authority granted by the Medicare statute, the Secretary had extended the application of return on equity to other proprietary providers. Congress recognized this discretion when it passed section 9107 of Pub. L. 99–272. That is, except for inpatient hospital services (amended section 1886(g)(2) of the Act) and SNFs (amended section 1861(v)(1)(B) of the Act), Congress left to the Secretary the decision of whether to pay a return on equity to other providers (new section 1861(v)(1)(P) of the Act). Congress limited the Secretary's discretion solely by setting the allowable rate of return, if a return is paid.

We have decided that discontinuing the payment of return on equity for services furnished by nonhospital and non-SNF proprietary providers (as we recommended in our proposed rule) is appropriate. In the legislative history of Pub. L. 99–272, Congress expressed no intent that a return on equity be allowed to these providers or entities. Furthermore, we continue to believe that reasonable cost reimbursement, without an allowance for payment of return on equity, is adequate to maintain the availability of services to beneficiaries.

E. Discussion of Public Comments

As noted earlier; we received timely comments on our proposed rule from 19 commenters. The commenters consisted of providers, health care entities, associations representing HHAs and SNFs, State health facilities associations, an intermediary, an association that represents outpatient physical therapists and CORFs, and a national association of rehabilitation agencies. To a large extent, the comments have been made moot by Congress' passage of Pub. L. 99–272. As a result, in most cases it is not necessary to respond to the comments. However, there are certain points raised by commenters for which we are providing responses.

Comment—One commenter stated that the proposed changes to return on equity capital would create an incentive to borrow at rates higher than return on equity rates. Entities would incur interest expense that would be reimbursed by Medicare and the rate of interest would be higher than the return on equity rates because the loans would be largely unsecured and relatively risky.

Response—We do not believe that the elimination or reduction of return on equity creates an incentive to borrow money. In the case of HHAs, most are not capital-intensive in their operations and, in fact, many HHAs lease their facilities and thus are not dependent on return on equity payments to operate and remain competitive. CORFs, OPAs, RHCs, and Histo-labs are primarily nonprofit organizations and would not be significantly affected by the elimination of return on equity.

With regard to OPTs, we cannot be certain of the potential effect of eliminating return on equity because, as stated in our proposed rule, we do not have adequate cost report data from participating OPTs. Where the provider finds it necessary and proper to borrow money, the Medicare program recognizes interest paid on provider debts. The program's recognition of interest expense is subject to well-established policies in regulations at § 413.153 and in Chapter 2 of the Provider Reimbursement Manual (HCFA Pub. 15–1)).

Comment—A commenter believes that changing policy with respect to payment of a return on equity capital creates an incentive to lease capital equipment rather than purchase it.

Response—We disagree with this comment. We have no evidence that nonproprietary providers (providers that do not receive a return on equity capital) lease capital assets to a greater extent than proprietary providers (providers that receive a return on equity capital). Therefore, placing these two classes of providers on a more equal footing concerning capital payments would not, in our view, cause changes in behavior that have not occurred while previous equity capital policies have been in effect. In any case, the Medicare program will continue to pay an appropriate share of the cost of capital assets, whether purchased or leased, according to the law and regulations.

Comment—A commenter believes that our proposed reductions violate congressional intent as evidenced by legislative history. The commenter stated that Congress—

- Originally established the 150 percent rate level; and
- Was aware of the dichotomy between the rate level for inpatient hospital services and other services and chose to take no action to reduce the "other" rate to the level of inpatient hospital services.

Response—We believe that our proposed reductions in return on equity payment levels are consistent with congressional intent, especially as evidenced by the enactment of section 9107 of Pub. L. 99–272 subsequent to the publication of the proposed rule. As stated above, this section of the law phases our return on equity payments for inpatient hospital services, reduces the return on equity rate for other than inpatient hospital services to 100 percent, and affirms the Secretary's discretionary authority to determine whether to pay return on equity for other than hospital inpatient and SNF services.

Comment—One commenter stated that the payment of a return on equity is necessary to insure proper financing for HHA services requiring capital-related expenditures.

Response—As discussed in greater detail below, the HHA industry is not capital-intensive (capital costs generally being less than three percent of HHA operating costs). Also as discussed below, the expansion in the number of HHAs is well-documented, and we believe that Medicare payment without a return on equity will be adequate to maintain the availability of HHA services to program beneficiaries' as well as to encourage establishment of HHAs in areas where their numbers are insufficient to deal with beneficiaries needs. Also, as indicated above, when a provider finds it necessary and proper to borrow money in connection with capital inprovements for rendering health care services, the program pays its appropriate share of qualified interest payments.

Comment—Commenters stated that the payment of a return on equity is necessary to ensure a profit for investors and that elimination of return on equity will result in non-Medicare payors subsidizing costs of services to Medicare patients.

Response—Medicare's responsibility is to ensure that it pays an appropriate share of a provider's costs of treating Medicare beneficiaries. To the extent that an allowance for return for investors has been desirable in the past to attract capital investment, we have provided for its payment. However, as previously stated, there are other available sources of capitalization, and when providers incur necessary and proper interest expense, the program pays its appropriate share of such interest. For these reasons, we do not expect that other payors will end up subsidizing the care provided to Medicare beneficiaries. Moreover, under the provisions of section 9107 of Pub. L. 99–272, we have clear direction from Congress concerning payment of return on equity capital.

Comment—A commenter stated that the elimination of a return on equity discriminates against proprietary HHAs, and that it further penalizes HHAs that have already been subject to cost caps and reductions.

Response—On the contrary, under the statutory language of section 9107 of Pub. L. 99–272 (for example, the phasing out of return on equity for inpatient hospital services and the reduction of the return on equity rate for other provider services), we are not discriminating against HHAs, or any other type of provider.

II. Elimination of the Exception for Newly Established HHAs From the Cost Limits

A. Background and Proposed Rule

Section 1861(v)(1) of the Act authorizes the Secretary to set prospective limits on the costs that are reimbursed under Medicare. The limits may be applied to the direct or indirect overall costs or to costs incurred for specific items or services furnished by a Medicare provider. Regulations implementing this authority are set forth at § 413.30. In addition to establishing limits on provider costs, § 413.30(f) specifies exceptions under which providers may request relief from the cost limits. The exception for a "newly-established HHA" (§ 413.30(f)(7)) defines one of the bases for which an HHA's limits may be adjusted.

Section 413.30(f)(7) enables a newly-established HHA to file for an exception to the cost limits if it can demonstrate that—

- It has provided, under present and previous ownership for a period of less than three full years, home health care services equivalent to those that would have been covered if the agency had a Medicare provider agreement in effect;
- Its variable operating costs were reasonable in relation to its utilization during the fiscal cost reporting period for which the exception is requested; and
- Its fixed operating costs are reasonable in relation to a realistic projection of utilization to be achieved at the end of the provider's second full year of operation in the program; that is, the reporting year containing the 24th month after the start of the provider's first cost reporting period.

When the newly-established HHA exception was initially adopted in 1979, there were approximately 2,500 HHAs participating in the Medicare program. The original intent of this was to encourage home care by neutralizing the effects of cost limits upon new health care agencies. Representatives of HHAs contended that new agencies were financially at risk because they were unable to enter the market with a sufficient patient population to generate the volume of visits required to offset their fixed costs. They maintained that initial years of growth are dependent upon establishing sound referral arrangements.

Since HHAs, unlike inpatient facilities, can enter the market with little invested capital, a new provider exemption under § 413.30(e)(2) such as that granted to new hospitals and SNFs was determined to be inappropriate.

At that time, we concluded that a blanket exemption would have resulted in an unwarranted competitive advantage for new market entrants.

However, to encourage growth of HHAs in underserved areas, a "new HHA" exception was established to grant relief to those new agencies whose higher initial costs of operation can be traced to low utilization associated with entering the health care market without an established referral system. HHAs that have merely changed ownership or have been operating in the health care field providing substantially the same type of services as a participating HHA to private pay patients have not qualified under this section.

Subsequent to the creation of this exception in 1979, the number of participating HHAs had dramatically increased to over 5,900 by the end of 1985. This significant increase is mostly the outgrowth of a legislative change to section 1861(o) of the Act that relaxed the licensure requirements for proprietary HHAs (section 930(n)(2) of the Omnibus Budget Reconciliation Act of 1980 (Pub. L. 96–499)). From July 1, 1981, when the proprietary licensure requirement was deleted, to July 1, 1984, approximately 1,700 new agencies were approved for participation in Medicare. Indeed, the average annual rate of growth of participating HHAs between 1981 and 1984 (14 percent) was twice that experienced between 1979 and 1981 (seven percent). These facts indicate that, as a means of serving to encourage expansion in the HHA industry, the new-HHA exception was less important than the relaxation of licensure requirements.

We believe it desirable for all new agencies to monitor their costs and growth in each discipline, to institute sound management planning and to make prudent management decisions to minimize the disallowance of costs due to cost limitations. The elimination of the "new HHA" exception, as we proposed in the February, 20, 1986 notice of proposed rulemaking, is intended to prevent the sheltering of inefficient providers and to reduce inappropriate payment from the Medicare Trust Fund to these agencies. Continuing to recognize higher fixed costs simply because an HHA is "new" may merely support the ongoing operation of certain HHAs that otherwise are not viable enterprises. Moreover, payments for higher costs based on exceptions granted to new agencies result in increased expenditures, exacerbating the fiscal problems of the Medicare Trust Fund. Therefore, considering the recent increase in the number of HHAs nationwide, and the need to protect the Trust Fund from unnecessary expenditures, we believe continuation of this specific exception would be an imprudent decision.

In addition, as a result of the influx of new agencies, many established providers located in areas where the beneficiary population does not support additional agencies have become more vocal in expressing their belief that they are disadvantaged by the new HHA exception, which they believe subsidizes a newly established agency. They argue that this provision absolves health care providers expanding into the home care market from assuming the normal risk of opening a new business enterprise and diminishes the need for sound management planning. Since many of the costs directly related to initial development are start-up and organizational costs reimbursable under the Medicare program, established agencies contend that the new HHA exception providers a program subsidy for fixed costs where none is warranted. They believe that other costs that are directly related to patient care are controllable through careful management planning.

For all of these reasons, we believe that our original justification for

establishing a distinct exception for new HHAs is no longer valid. Therefore, we are removing § 413.30(f)(7) from the regulations to eliminate this exception. We note that § 413.30(f) contains other exception provisions that would continue to apply to all HHAs (for example, atypical services and extraordinary circumstances).

B. Public Comments

We received 12 timely sets of comments concerning the proposed elimination of the newly-established HHA exception. The commenters were national and state associations, HHAs, associations representing providers of health services, and other related parties. Several of the commenters supported our proposal and made the following statements regarding the new HHA exception:

- The exception has led to the establishment of HHAs without proper financial resources or proper analyses of market demands
- It has led to overutilization of home care services.
- It has resulted in a subsidy to new agencies that has disadvantaged established agencies.
- It has caused an over-proliferation of providers that has resulted in financial harm to the Medicare program, established HHAs, and new HHAs.

Other comments regarding this particular issue and our responses to these comments are discussed below.

Comment—Several commenters stated that the exception for newly-established HHAs should be continued because it takes time to develop the referral base needed to provide an ongoing source of capital. In addition, others stated that this problem is more difficult for HHAs in rural areas and that we should provide a separate exception for these HHAs.

Response—By the end of 1985, 81 percent of all new HHAs being certified for participation in the Medicare program were either hospital-based or proprietary. These HHAs have access to altenative sources of financing that were not available to the nonprofit agencies that dominated the industry prior to 1981. The hospital-based HHAs (40 percent of the new market entrants) enter with an established referral base and can reduce start up costs by utilizing existing staff and facilities. These HHAs also have the financial resources of the hospital to provide the necessary capital. In addition, since capital costs are less than three percent of total operating costs for HHAs, and HHA can enter the program with very little investment needed for physical assets and with sound management and financial planning can manage its costs (for example, adopt flexible staffing patterns and maintain minimal fixed assets) during the start-up period so as not to need a subsidy from the Medicare trust funds.

Finally, § 413.30(f) contains several other exceptions that could be granted to an HHA that incurs reasonable costs in providing patient care services but whose costs still exceed its Medicare cost limits. For example, agencies that incur higher transportation costs because they are serving patients in underserved areas may qualify for an exception under § 413.30(F)(2)—extraordinary circumstances. Accordingly, a new HHA exception is not needed specifically for agencies in underserved areas.

Comment—One commenter stated that if we eliminate the new HHA exception, we should provide for the inclusion of new agency costs in the computation of the HHA cost limits.

Response—The latest schedule of HHA cost limits was published in the **Federal Register** on May 30, 1986 (51 FR 19734). These cost limits were developed using the costs of both *new* and *established* providers. We have no intention of excluding new provider cost data from this process in the future.

Comment—Two commenters stated that HCFA has not presented sufficient data to justify the elimination of the newly-established HHA exception.

Response—As a result of the enactment of Pub. L. 96–499, which relaxed the licensure requirements for proprietary HHAs effective July 1, 1981, the home health industry has undergone many changes. As we stated above, average annual growth in the number of participating agencies between 1981 and 1984 rose to 14 percent, twice that of the seven percent growth experienced between 1979 and 1981. It is apparent that the greater catalyst for expansion of new HHAs has been the relaxation of the licensure requirements and not the new provider exception, which was established in regulations in 1979. Also, as previously stated, this is not a capital-intensive industry and HHAs can control their staffing patterns.

Comment—Several commenters stated that because hospitals reimbursed under the prospective payment system are discharging patients earlier, the need for new agencies is greatly increased.

Response—We disagree. We do not believe that the elimination of the newly-established HHA exception will result in new agencies being deterred from entering the market. The facts demonstrate and several commenters have stated that there is increased demand for home health care services. This demand, plus the current level of reimbursement paid to established agencies, should provide sufficient inducement for HHAs to enter the market.

III. Regulatory Impact Statement and Flexibility Analysis

A. Introduction

Executive Order 12291 (E.O. 12291) requires us to prepare and publish a final regulatory impact analysis for final regulations that are likely to meet criteria for a "major rule". A major rule is one that would result in:

- An annual effect on the economy of $100 million or more;
- A major increase in costs of prices for consumers, individual industries, Federal, State, or local government agencies, or any geographical regions; or
- Significant adverse effects on competition, employment, investment, productivity, innovation, or the ability of United States-based enterprises to compete with foreign-based enterprises in domestic or export markets.

We also prepare and publish a final regulatory flexibility analysis for final rules that is consistent with the Regulatory Flexibility Act (RFA) (5 U.S.C. 601 through 612) unless the Secretary certifies that the rule will not 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 provisions contained in this rule are not expected to result in an annual economic impact of $100 million or more, therefore, this is not a major rule. A significant number of small entities, however, are expected to be substantially affected by this rule. In addition, while the provisions of section 1886(g)(2) of the Act (which mandate the phase-out of payment for return on equity for inpatient hospital services) were effective with cost reporting periods beginning on or after October 1, 1986, section 9321(c) of Pub. L. 99–509 precludes issuance of a final rule dealing with capital-related costs before September 1, 1987. Consequently, we will publish necessary conforming changes to the regulations at a later date. Nonetheless, we believe it appropriate to discuss the impact of phasing-out these return on equity payments for inpatient hospital services in this document. Also, we believe this to be an opportune time to discuss the effects of phasing-out return on equity payments for hospital inpatient services because of the interactive effects this

may have for investment decisions and the demand for provider services in other sections of the industry. For example, the phase-out may result in a shift of investments and increase demand for outpatient services and other post-acute care treatment modalities and providers of these services. Thus, we are providing voluntarily a regulatory impact analysis that meets the requirements of the Executive Order as well as providing an analysis that is consistent with the RFA.

This rule is not expected to result in payment reductions to providers or physicians of $50 million or more during FY 1988. Therefore, it can be published at this time without violating section 9321(d) of Pub. L. 99–509, which prohibits the Secretary from issuing any final rules or notices between October 21, 1986 and September 1, 1987 that would result in payment reductions to hospitals or physicians of $50 million or more for FY 1988.

B. Return on Equity

1. Entities Affected

As of June 1986, there were about 10,300 proprietary providers participating in the Medicare program. This represents approximately 43 percent of all providers participating in the Medicare program. Proprietary hospitals account for about four percent of proprietary providers and for about 16 percent of all participating hospitals. Typically, proprietary hospitals have under 200 beds, and are located predominantly in the southern and western parts of the country. By contrast, proprietary nursing homes (SNFs) account for about 69 percent of all participating SFNs and, are distributed geographically roughly in the same proportion as not-for-profit and government controlled SNFs. Also, many proprietary hospitals and nursing homes are now chain controlled facilities.

Among other provider types, only OPTs have a sizable proportion of proprietary facilities. Proprietry OPTs represent about 71 percent of all participating clinics and are, for the most part, provider based. Proprietary HHAs comprise only 32 percent of all HHAs participating in the Medicare program.

Because §§ 447.253(b)(2) and 447.321, limit Federal financial participation (FFP) for certain categories of providers to an aggregate upper limit determined by the amount payable under Medicare principles under comparable circumstances, some providers that participate in the Medicaid program may also be affected by this regulation. A number of States adopt Medicare principles directly for Medicaid payment. Most Medicare providers also participate in Medicaid and thus, as a result of these regulations, could have payment for return on equity reduced under both programs.

In addition to providers that participate in both programs, there are about 2,000 SNFs and two categories of providers that participate only in the Medicaid program: intermediate care facilities (ICFs) and intermediate care facilities for the mentally retarded (ICFs/MR). As of June 1986, there were about 1,230 proprietary SNFs, 4,300 proprietary ICFs and 711 proprietary ICFs/MR participating only in Medicaid State programs. Proprietary ICFs and ICFs/MR represent approximately 76 percent and 22 percent respectively of all ICFs and ICFs/MR treating Medicaid recipients. As explained later in this impact analysis, we cannot identify which Medicaid providers will be affected by these regulations.

2. Expected Impact

We are reducing return on equity payments to SNFs, hospital outpatient services and other nonhospital and non-SNF providers in accordance with sections 1861(v)(1)(B) and (P) of the Act, as enacted and amended by section 9107(b) of Pub. L. 99–272, to be effective with cost reporting periods beginning on or after October 1, 1985. As a result, we expect to realize Medicare program savings of approximately $15 million for FY 1986. These savings will be achieved through the following reductions to providers:

Pub. L. 99–272 Savings in FY 1986 (rounded to the nearest $5 million).

Hospital Outpatient	$5
SNFs	5
HHAs and others	5

Section 1886(g)(2) of the Act, as amended by section 9107(a) of Pub. L. 99–272 requires us to phase out payment for return on equity capital for inpatient hospital services over three fiscal years beginning in FY 1987. In addition, on our own initiative we are eliminating return on equity payments to HHAs and other nonhospital and non-SNF providers to be effective 30 days following publication of this document. The following table shows the expected Medicare program savings from these reductions including continuation of payments for return on equity to SNFs and hospital outpatient services equal to the average interest rate earned on Part A Trust Fund obligations.

ELIMINATION OF ROE FOR HOSPITAL INPATIENT SERVICES, FOR NONHOSPITAL, NON-SNF PROVIDERS, AND REDUCTION OF ROE TO SNFS AND FOR HOSPITAL OUTPATIENT SERVICES

[Savings (in millions)*]

Provider	FY 1987	FY 1988	FY 1989	FY 1990	FY 1991
Hospital Inpatient	$40	$110	$160	$210	$240
Hospital Outpatient	10	15	20	20	20
SNF	15	15	15	15	15
HHA and others	10	10	10	10	10

* Inpatient hospital-related estimates are rounded to the nearest $10 million; hospital outpatient, SNF and HHA estimates are rounded to the nearest $5 million.

The principal factors affecting year-to-year changes in projected savings are projected utilization and the expected interest rates on Part A Trust Fund bonds. For example, SNF Medicare utilization is not expected to increase significantly over the next five fiscal years, while interest rates are projected to decrease, thus resulting in a fairly flat annual savings rate. By contrast, hospital outpatient Medicare utilization is expected to increase significantly over the next five fiscal years causing a growth in savings over time. Medicare utilization of HHA and other provider services is expected to increase somewhat, resulting in a relatively constant year-to-year savings rate after the expected decline in interest rates is taken into account. Savings attributable to the elimination of return on equity payments for hospital inpatient services will continue to grow through FY 1991 because payments for return on equity to some hospitals for inpatient services will not be completely eliminated until FY 1990.

3. General Considerations

It is impossible to predict with precision the economic impact of this regulation on provider profit margins and behavior, both because of limited data and our inability to model the

pertinent variables in a way that would permit us to estimate the financial effects of these regulations on different classes of providers. Even with a suitable model and the data for determining the impact, it would be difficult to predict how providers will respond. Their responses will be conditioned by a set of factors influencing investors' or stockholders' investment decisions for which we have no data.

It is often claimed that payment reductions may have the effect of limiting beneficiary access to care. This may occur either because providers elect to furnish fewer services to Medicare beneficiaries, or because they cease operations in response to reduced payments. However, the relationship between Medicare payments and access is complex and is dependent on each provider's response to the total payment amount a provider receives for treating Medicare patients. Also, provider actions that may restrict access would be conditioned by the availability of alternate sources of revenue or (particularly in the case of proprietary providers) other investment opportunities open to owners or stockholders. Clearly, the level of Medicare payment plays a part in investment decisions, but we believe in most cases it is but one of several factors that investors must weigh in responding to this final rule. Generally, investors will withdraw their equity holdings from an enterprise if the overall economic rate of return of the enterprise falls below the rate of return investors demand from an investment in order to maintain their financial interest in the investment. The economic rate of return on an investment is usually defined as the total cash flow expected to be received over the life of the investment, discounted by a factor reflecting the required rate of return divided by the total cash amount expected to be paid out over the life of the investment, also discounted by the required rate of return.[1]

The variables affecting the rate of return required to maintain an investor's financial interest in an investment include: the investor's overall investment portfolio, the investor's marginal tax rate, the rate of return on alternative investments, the level of risk associated with each investment and the amount of risk the investor is willing to assume, and nonfinancial considerations. (An example of the latter may be an investor's concern with the welfare of the community as well as with optimizing the rate of return.) All of these factors affect investment decisions and are expressed quantitatively as the discount factor in the formula described above for determining the rate of return on an investment.

4. Hospitals

We do not believe that the phasing out and eventual elimination of payments for return on equity for inpatient services will, by itself, after proprietary hospitals treatment of Medicare beneficiaries. As shown in our discussion of hospital "profit" margins in the final rule published in the **Federal Register** (51 FR 31454) on September 3, 1986, many hospitals have achieved second "profits" over the past two years. For FY 1987, the projected reduction in payment for return on equity for both inpatient and outpatient services represents about one percent of total payments to proprietary hospitals. The combination of high profits, the small reduction in payments and declining occupancy (which has resulted in increased competition among hospitals to fill the available beds) should work to preserve beneficiary access to hospital care.

As noted above, we expect Medicare utilization of hospital outpatient services to increase over the coming years as hospitals continue to transfer patient care services from the inpatient setting. This transfer is partially in response to technological innovations that have enabled providers to perform procedures on an ambulatory basis where, previously, inpatient stays were required. In addition to technological advances, Professional Review Organization preadmission review of Medicare inpatient admissions and the incentives of the prospective payment system encourage the movement of services into the outpatient setting. We do not believe that the reduction of the return on equity for hospital outpatient services will affect this trend.

5. Skilled Nursing Facilities

There are very limited data on the unmet Medicare demand for SNF level beds. Using the number of hospital "back-up" days as a proxy measure of the demand for SNF of ICF beds, the recent report to Congress on the SNF benefit under Medicare [2] cities estimates of beween 0.7 million and 7.2 million "back-up" days in FY 1980. "Back-up" days are the number of days patients must remain in the hospital because there are no suitable nursing home beds to which they can be transferred. We have referred to these days in other documents as either "inappropriate level of care" days (51 FR 4728), or as "alternate placement" days (49 FR 234). Although the report cautions against relying completely upon these data—noting that the data may be more expressive of Medicaid "back-up" days than of Medicare—the authors do suggest that Medicare demand for nursing home beds may exceed available supply in some areas.

Access to nursing home beds depends heavily on local market conditions. Such factors as the demand from nongovernment insured patients who are able to pay the asking price for nursing beds, State Medicaid reimbursement policies, and the availability of other health delivery modalities that could substitute for nursing home care (for example, home health services) will vary from one locality to another. The majority of patients in SNFs are Medicaid and private pay. In communities where the demand for SNF beds is high for these patients, reducing payments for return on equity may decrease the supply of beds available to Medicare beneficiaries. At the same time, the Medicare prospective payment system creates financial pressures for hospitals and physicians to improve their practice patterns and reduce the time patients remain in the hospital to the minimum number of days that are truly medically necessary for proper care. These pressure may increase the demand for SNF beds for Medicare patients. In communities where the demand for SNF beds is already high because of these various pressures, the effect of reducing payments for return on equity may serve to further tighten demand for SNF beds by reducing the supply of beds available to Medicare beneficiaries. Depending on local market conditions. SNF operators may elect to no longer participate in the Medicare and/or Medicaid programs, thereby making more beds available for higher paying privately insured or self-pay patients; or owners may decide to reduce their investment in new bed construction or reduce the current level

[1] Total cash received is defined as total revenues including capital related payments and return on equity payments. Total cash outlays includes only actual cash expenditures for capital, interest, dividends, taxes and general operating costs. In this context, depreciation expense serves only to reduce the provider's tax liability (thereby reducing cash outlays) but is not, itself, a cash outlay and is therefore not included in computing the economic rate of return.

[2] *Report to Congress: Study of the Skilled Nursing Facility Benefit Under Medicare*, Health Care Financing Administration, Department of Health and Human Services, Office of Policy Analysis: January 1985, page 71.

of beds available, thus driving up the cost of SNF care for private care patients as well as for Medicare and Medicaid patients.

6. Home Health Agencies and Other Proprietary Providers

Because of the rapid growth in the number of HHAs, which results, in part, from the small capital investment required to set up an agency, we doubt that elimination of return or equity payments will have a significant effect on the supply of these services. More lenient licensure requirements and the trend toward substitution on nonhospital services for services that had traditionally been provided on a hospital inpatient basis all have led to a rapid growth in this segment of the industry. It seems to us highly unlikely that the comparatively small reduction in payments that HHAs would experience (primarily because of the small amount of capital involved) will alter this continued growth pattern.

While we posses little data on which to determine the effects of eliminating return on equity payments for other non-hospital and non-nursing home providers, we believe that many of these providers have capitalization structures similar to HHAs, and therefore, the impact of this regulation will be minimal. Most nonhospital providers have relatively small capital investments and, thus, their return on equity payments represent a small percentage of their total revenue. Beneficiary access to these provider services should not be impaired by this regulation.

7. Effect on Medicaid Providers

As discussed earlier, under §§ 447.253(b)(2) and 447.321, FFP is limited (with respect to certain categories of providers) to an aggregate upper limit determined by the amount Medicare would pay under comparable circumstances. The provision to reduce payments for return on equity to SNFs and for outpatient hospital services and to eliminate return on equity payments for other providers may affect the upper limit allowable for FFP under Medicaid.

We stated above that we cannot determine precisely how this regulation will affect Medicare providers because of a lack of data and the impossibility of calculating all the variables involved. Attempting to estimate the effect this regulation will have on Medicaid providers is even more difficult because the limit on FFP applies to the aggregate payment amount and not to the specific amount a State may reimburse for return on equity (if, in fact, the State reimburses for this item). As a result, a State may not have to modify its payments for return on equity. It could meet the upper limit requirement by modifying the payment methodology in other ways, or if the State's projected Medicaid payments are below the upper limit, it may not need to modify its payment methodology at all. An affected State may also choose to ignore the upper limit and continue to pay providers for return on equity without FFP. Because we cannot predict how this regulation will affect a State's upper payment limit or know how a State will respond to the change in the upper limit, we are unable to provide a specific analysis of the effects of this regulation on Medicaid providers.

In those States that elect to reduce provider payment in response to a drop in the FFP upper limit, we believe that Medicaid providers would respond in similar ways to Medicare providers. We believe that because of excess bed capacity and the efficiencies achieved in recent years, hospitals will not limit access to Medicaid patients. Long-term care facilities, however, may seek to limit access where the demand from patients covered under other types of third party coverage or private pay is high. Responses to limited access by nonhospital or non-long-term care providers will again depend on local economic and market factors.

C. Elimination of the Exception for Newly-Established HHAs from the Cost Limits

As stated previously in this preamble, the initial reason for providing the exception to the cost limits for new HHAs was to minimize financial barriers to HHAs wanting to enter Medicare markets for the first time, especially in underserved areas. However, because of the rapid increase in the number of new HHAs that have entered the market following the adoption of more lenient licensure requirements for proprietary HHAs, this rationale no longer appears to be valid.

Evidence acquired during the past few years concerning the changing composition of HHAs suggests that financing may no longer be a significant obstacle to entering the market place. In FY 1980 (the first year of the "new HHA" exception), slightly more than one-half (57.7 percent) of all the new HHAs certified under Medicare were either hospital-based or proprietary agencies. Hospital-based and proprietary HHAs at that time represented less than 25 percent of the total Medicare participating HHAs. In FY 1981, the percentage of new hospital-based and proprietary agencies entering the market increased to 61.7 percent. By the end of FY 1985, slightly more than 80 percent (81.1 percent) of all new agencies being certified for participation in the Medicare program were either hospital-based or proprietary. We expect this trend to continue for the foreseeable future.

The fact that eight out of ten new agencies entering the market are either hospital-based or proprietary agencies strongly suggests that these agencies have access to alternative sources of financing that are not available to nonprofit agencies, which dominated the home health industry prior to 1981. Moreover, hosptial-based HHAs (which comprise nearly 40 percent of the new market entrants) enter with an established market, thereby further minimizing the need for the financial relief intended by the new HHA exception. Also, hospital-based programs can significantly reduce their start-up costs for service delivery by utilizing existing staff and facilities to perform patient care services.

While hospital-based and proprietary agencies may have access to financial resources and patient populations that nonprofit and free-standing agencies may not have, we believe that the service delivery mode and the relatively small capital investment required to start an agency make it quite easy for new free-standing and nonprofit agencies to begin operations without the aid of a new HHA exception. On average, capital-related costs for an HHA represent less than three percent of its total operating costs. By comparison, capital-related costs for the average SNF will be three times as much as for an HHA. Also, the nature of home health services enables HHAs to adopt extremely flexible staffing patterns and to maintain minimal fixed assets, thereby giving them a degree of control over their costs during the initial years of service that hospitals and SNFs do not have.

We are presently unable to quantify the savings that may result from the proposed elimination of the new HHA exception. Historically, exception amounts requested by new providers have ranged from less than $1,000 to over $100,000 with an average request of $20,000. The amount approved, however, frequently is lower than the amount requested, sometimes by as much as 50 percent. Yet, because most exceptions that we approve are interim approvals, pending audit, we do not know what the final exception amounts will be. Thus far, we have very few "final" exceptions. In addition, the rapid growth of the HHA industry makes prediction of number of future new HHA exceptions

very uncertain. Also, the total number of HHAs affected by elimination of the exception is likely to be small, since all agencies will continue to be eligible to apply for other exceptions under § 413.30(f).

Based on program experience, we expect the amount of monies involved in the elimination of this exception to be insignificant in relation to overall average Medicare revenues to HHAs.

D. Response to Comments

Comment: A commenter objected to our use of a chart in the initial impact analysis showing historical Medicare payment rates for return on equity capital compared to rates of return earned by public utilities and after tax profits for major industries. The commenter believes that the chart was misleading and based on incomplete data. Comparisons of pre-tax Medicare payment rates for return on equity with after-tax private industry profit margins are unfair, and the data upon the which comparisons are based are out of date.

Response: We agree that the chart used in the initial impact analysis in support of our decision to reduce return on equity payments was inappropriate. In this final impact analysis we make no reference to the chart.

Comment: A commenter states that our initial impact analysis underestimated the potential effects on SNFs of reducing payments on return on equity because we failed to consider the link between Medicare and Medicaid payment principles.

Response: We agree that we failed to discuss the possible consequences of the proposed rule on Medicaid payments to providers. In our final impact analysis, we do discuss possible effects this regulation may have on Medicaid payments to providers. However, because of the different payment methodologies States have adopted and the lack of data with respect to the aggregate upper limits on Medicaid payments in each State, we cannot be certain how this regulation will affect Medicaid payments.

Comment: A commenter complained that we minimized the potential effects of the proposed rule on SNFs by arguing that chain-operated and hospital-based SNFs have access to alternate funds and markets that could mitigate the reduction in payments for return on equity. The commenter states that the area where its facility is located does not permit chain-operated facilities.

Response: We agree with the commenter that our analysis did not address the effects of the proposed regulation on independent, free-standing facilities. In the final impact analysis, we stated that there is uncertainty in this area owing to the number of variables involved in any investment decision and the lack of data. However, we do speculate that, in areas where the demand for SNF beds is high from non-Medicare patients, our regulation may cause nursing homes to limit the number of beds made available to Medicare patients.

IV. Other Required Information

A. Applicability

The change concerning the interim reduction of the rate of return on equity capital payment for all nonhospital and non-SNF properitary provider services applies to cost reporting periods beginning on or after October 1, 1985 and before the effective date of this final rule.

The change concerning the rate of return on equity capital for services provided by properietary SNFs and for outpatient hospital services is applicable to cost reporting periods beginning on or after October 1, 1985.

All other changes are applicable to cost reporting periods beginning on or after July 6, 1987.

B. Paperwork Reduction Act

These changes do not impose information collection requirements; consequently, they need not be reviewed by the Executive Office of Management and Budget under the authority of the Paperwork Reduction Act of 1980 (44 U.S.C. 3501–3511).

C. Public Comment Period and Waiver of Proposed Rulemaking

As we have discussed at length in this preamble, all of the changes in this final rule affecting Medicare rules on the allowance for a return on equity capital were discribed for public comment in the proposed rule or mandated by section 9107 of Pub. L. 99–272, or both.

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** for substantive changes in regulations such as reduction of the rate for all proprietary providers other than hospitals and SNFs authorized under section 9107(b) of Pub. L. 99–272. However, we may waive that procedure if we find good cause that proposed rulemaking is impractical, unnecessary, or contrary to the public interest.

Section 9115(b) of Pub. L. 99–272 provides that we may issue the regulations that implement section 9107 of Pub. L. 99–272 on an interim or other basis as may be necessary. Our reduction of the rate of return on equity capital payments for all proprietary providers other than hospitals and SNFs, for cost reporting periods beginning on or after October 1, 1985, but before the effective date of this final rule, is mandated by Congress under the provisions of section 9107(b)(1) of Pub. L. 99–272. Therefore, in the interest of updating our regulations concerning all aspects of the allowance for return on equity capital at the same time (other than for inpatient hospital services), we believe that notice of proposed rulemaking for the provisions of this final rule that implement section 9107(b) of Pub. L. 99–272 is unnecessary, and we find good cause to waive the procedure and to issue these provisions as final. However, since this change in regulations has not previously been subject to public comment, we are providing a 60-day comment period.

Since our decision to reduce the rate of return on equity capital payments for outpatient hospital services from a level of 150 percent to 100 percent was part of our proposed rule, and conforms to the provisions of section 9107(b) of Pub. L. 99–272, a new comment period for this provisions is unnecessary.

The provision of this final rule concerning reduction of the rate of return on equity capital for SNFs is mandated by section 9107(b)(2) of Pub. L. 99–272 and, further, is exempt from proposed rulemaking under section 9115(b) of Pub. L. 99–272. In addition, this provision was part of our proposed rule. Therefore, a new comment period for this provision would not be useful.

Finally, our decision concerning elimination of the allowance for a return of equity for all nonhospital and non-SNF providers was part of our proposed rule. The provisions of this rule implementing that decision are final without a further public comment period.

To summarize, we are providing a 60-day comment period on those provisions of this final rule that reduce the return on equity capital for all proprietary providers other than hospitals and SNFs, for cost reporting periods beginning on or after October 1, 1985, but before the effective date of this final rule (§ 413.157(b)(4)(i)).

Because of the large number of items of correspondence we normally receive on regulations, we cannot acknowledge or respond to them individually. However, we will consider all comments concerning the issue noted directly above that are received by the date and time specified in the "Dates" section of this preamble. If we decide that further rulemaking is necessary concerning this issue we will publish a final rule and respond to the comments in the preamble of that rule.

List of Subjects in 42 CFR Part 413

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 413, is amended as set forth below:

PART 413—PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END-STAGE RENAL DISEASE SERVICES

A. The authority citation for Part 413 continues to read as follows:

Authority: Secs. 1102, 1122, 1814(b), 1815, 1833(a), 1861(v), 1871, 1881, and 1886 of the Social Security Act as amended (42 U.S.C. 1302, 1320a–1, 1395f(b), 1395g, 1395l(a), 1395x(v), 1395hh, 1395rr, and 1395ww).

B. In Subpart A, § 413.5, the introductory language of paragraph (c) and paragraph (e) are revised to read as follows:

Subpart A—Introduction and General Rules

§ 413.5 Cost reimbursement; general.

* * * * *

(c) As formulated herein, the principles give recognition to such factors as depreciation, interests, bad debts, educational costs, compensation of owners, and an allowance for a reasonable return on equity capital of proprietary facilities. However, costs such as depreciation, interest on borrowed funds, a return on equity capital (in the case of certain properitary providers), and other costs related to certain capital expenditures are subject to the provisions of § 413.161, "Nonallowable costs related to certain capital expenditures." With respect to allowable costs some items of inclusion and exclusion are:

* * * * *

(e) A return on the equity capital of proprietary facilities, as described in § 413.157, is an allowance in addition to the reasonable cost of covered services furnished to beneficiaries.

* * * * *

Subpart C—Limits on Cost Reimbursement

§ 413.30 [Amended]

C. In Subpart C, § 413.30 is amended by removing and reserving paragraph (f)(7).

D. Subpart G is amended to read as follows:

Subpart G—Capital-Related Costs

1. Section 413.130 is amended by republishing the introductory language of paragraph (a) and by revising paragraph (a)(8) to read as follows:

§ 413.130 Introduction to capital-related costs.

(a) *General rule.* Capital-related costs and an allowance for return on equity are limited to the following:

* * * * *

(8) For certain proprietary providers, return on equity capital, as determined under § 413.157.

* * * * *

2. Section 413.157 is amended by revising paragraph (a); redesignating the current paragraph (b) as paragraph (c); adding a new paragraph (b); and revising the redesignated paragraph (c)(1) to read as follows:

§ 413.157 Return on equity capital of proprietary providers.

(a) *Definitions*

For purposes of this section—

"Proprietary provider" means a provider that is organized and operated with the expectation of earning a profit for its owners (as distinguished from a provider that is organized and operated on a nonprofit basis). Proprietary providers may be sole proprietorships, partnerships, or corporations. Effective for cost reporting periods beginning on or after July 6, 1987, the term applies only to proprietary hospitals and SNFs.

(b) *General rule.* A reasonable return on equity capital invested and used in the provision of patient care is paid as an allowance in addition to the reasonable cost of covered services furnished to beneficiaries by proprietar providers.

(1) *Rate of return applicable to proprietary providers for cost reporting periods beginning before July 6, 1987.* Except as provided in paragraphs (b)(2), (b)(3), and (b)(4) of this section, the amount allowable on an annual basis, for cost reporting periods beginning before July 6, 1987, is determined by multiplying the provider's equity capital by a percentage equal to one and one-half times the average of the rates of interest on special issues of public debt obligations issued for purchase by the Medicare Part A Trust Fund for each of the months during the provider's reporting period or portion thereof covered under the program.

(2) [Reserved]

(3) *Rate of return for proprietary SNFs and for outpatient hospital services.* For cost reporting periods beginning on or after October 1, 1985, the rate used in determining the return for SNFs and for outpatient hospital services is a percentage equal to the average of the rates of interest described in paragraph (b)(1) of this section.

(4) *Rate of return for proprietary service of all nonhospital and non-SNF providers.*

(i) For cost reporting periods beginning on or after October 1, 1985, but before July 6, 1987, the rate used in determining the return for services of all nonhospital and non-SNF providers is a percentage equal to the average of the rates of interest described in paragraph (b)(1) of this section.

(ii) For cost reporting periods beginning on or after July 6, 1987, there is no allowance for return on equity capital for nonhospital and non-SNF providers.

(c) *Application*—(1) *Computation of equity capital.* For purposes of computing the allowable return, the provider's equity capital means—

(i) The provider's investment in plant, property, and equipment related to patient care (net of depreciation) and funds deposited by a provider who leases plant, property, or equipment related to patient care and is required by the terms of the lease to deposit such funds (net of noncurrent debt related to such investment or deposited funds); and

(ii) Net working capital maintained for necessary and proper operation of patient care activities. However, debt representing loans from partners, stockholders, or related organizations on which interest payments would be allowable as costs but for the provisions of § 413.153(b)(3)(ii), is not subtracted in computing the amount of equity capital in order that the proceeds from such loans be treated as part of the provider's equity capital. In computing the amount of equity capital upon which a return is allowable, investment in facilities in recognized on the basis of the historical cost or other basis, used for depreciation

and other purposes under Part A of Medicare.

* * * * *

§ 413.161 [Amended]

3. In § 413.161(a), the first sentence, the word "certain" is inserted before the phrase "proprietary providers".

(Catalog of Federal Domestic Assistance Program No. 13.773, Medicare—Hospital Insurance; and No. 13.774, Medicare-Supplementary Medical Insurance)

Dated: March 16, 1987.

William L. Roper,

Administrator, Health Care Financing Administration.

Approved: May 1, 1987.

Otis R. Bowen,

Secretary.

[FR Doc. 87–12602 Filed 6–3–87; 8: 45 am]

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