

as they are defined in the Regulatory Flexibility Act, 5 U.S.C. 601-612. The reason for this certification is that these amendments would not directly affect any small entities. Only VA beneficiaries could be directly affected. Therefore, pursuant to 5 U.S.C. 605(b), these amendments are exempt from the initial and final regulatory flexibility analysis requirements of sections 603 and 604.

In accordance with Executive Order 12291, Federal Regulation, the Administrator has determined that these regulatory amendments are nonmajor for the following reasons:

1. They will not have an annual effect on the economy of \$100 million or more.
2. They will not cause a major increase in costs or prices.
3. They will not have 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.

(Catalog of Federal Domestic Assistance program numbers are 64.100 through 64.110.)

List of Subjects in 38 CFR Part 3

Administrative practices and procedure, Claims Handicapped, Health care, Pensions, Veterans.

Approved: April 25, 1988.

Thomas K. Turnage,
Administrator.

PART 3—[AMENDED]

38 CFR, Part 3, *Adjudication*, is amended to read:

§ 3.900 [Amended]

1. In § 3.900(d) remove the word "his" and add, in its place, the words "his or her."
2. In § 3.901, the introductory text of paragraph (c) and the last sentence of paragraph (d) are revised to read as follows:

§ 3.901 Fraud.

(c) *Forfeiture before September 2, 1959.* Where forfeiture for fraud was declared before September 2, 1959, in the case of a veteran entitled to disability compensation, the compensation payable except for the forfeiture may be paid to the veteran's spouse, children and parents provided the decision to apportion was authorized prior to September 2, 1959. The total amount payable will be the lesser of these amounts:

(Authority: 38 U.S.C. 3503(e))

(d) * * *

Where the veteran's rights have been forfeited, no part of his or her benefit may be paid to his or her dependents.

(Authority: 38 U.S.C. 3503 (a), (d), (e))

3. In § 3.902(b) remove the word "he" and add, in its place, the words "he or she."

4. In § 3.902 the introductory text of paragraphs (c), (c)(1) and (c)(2), and paragraph (e) are revised to read as follows:

§ 3.902 Treasonable acts.

(c) *Forfeiture before September 2, 1959.* Where forfeiture for treasonable acts was declared before September 2, 1959, the Administrator may pay any part of benefits so forfeited to the dependents of the person provided the decision to apportion was authorized prior to September 2, 1959, except that the amount may not be in excess of that which the dependent would be entitled to as a death benefit.

(Authority: 38 U.S.C. 3504(c))

(1) *Compensation.* Whenever a veteran entitled to disability compensation has forfeited his or her right, any part of the compensation payable except for the forfeiture may be paid to the veteran's spouse, children and parents. The total amount payable will be the lesser of these amounts:

(2) *Pension.* Whenever a veteran entitled to pension has forfeited his or her right, any part of the pension payable except for the forfeiture provision may be paid to the veteran's spouse and children. The total amount payable will be the lesser of these amounts:

(e) *Children.* A treasonable act committed by a child or children, regardless of age, who are in the surviving spouse's custody and included in an award to such person will not affect the award to the surviving spouse.

§ 3.903 [Amended]

5. In § 3.903(a)(4) remove the citation at the end which reads "(Pub. L. 92-128; 85 Stat. 347)".

6. In § 34.904, paragraph (a) and the first sentence in paragraph (b) are revised to read as follows:

§ 3.904 Effect of forfeiture after veteran's death.

(a) *Fraud.* Whenever a veteran has forfeited his or her right by reason of fraud, his or her surviving dependents upon proper application may be paid pension, compensation, or dependency and indemnity compensation, if

otherwise eligible. No benefits are payable to any person who participated in the fraud causing the forfeiture.

(Authority: 38 U.S.C. 3503(c))

(b) *Treasonable acts.* Death benefits may be paid as provided in paragraph (a) of this section where forfeiture by reason of a treasonable act was declared before September 2, 1959, and such benefits were authorized prior to that date. * * *

7. In § 3.905 paragraphs (a) and (b), remove the words "Chief Attorney" wherever they appear and add, in their place, the words "District Counsel."

8. In § 3.905, paragraph (b)(5) is revised to read as follows:

§ 3.905 Declaration of forfeiture or remission of forfeiture.

(b) * * *

(5) The right to a hearing within 60 days, with representation by counsel of the person's own choosing, that fees for the representation are limited in accordance with 38 U.S.C. 3404(c) and that no expenses incurred by a claimant, counsel or witness will be paid by the VA.

[FR Doc. 88-11018 Filed 5-18-88; 8:45 am]

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ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 52

[A-1-FRL-3375-4]

Approval and Promulgation of Air Quality Implementation Plans; Connecticut; Group III CTG Regulations and Miscellaneous Amendments

AGENCY: Environmental Protection Agency (EPA).

ACTION: Final rule.

SUMMARY: EPA is approving State Implementation Plan (SIP) revisions submitted by the State of Connecticut. These revisions require reasonably available control technology (RACT) to reduce volatile organic compound (VOC) emissions from synthetic organic chemical and polymer manufacturing equipment and from polystyrene manufacturing equipment. The revisions also include amendments clarifying VOC compliance methods for surface coating operations. The intended effect of this action is to approve regulations adopted by the State fulfill commitments

made in its fully approved ozone attainment plan in accordance with section 110 of the Clean Air Act.

EFFECTIVE DATE: This rule will become effective on June 20, 1988.

ADDRESSES: Copies of the documents relevant to this action are available for public inspection during normal business hours at the Air Management Division, JFK Federal Building, Room 2311, Boston, MA 02203; and the Air Compliance Unit, Department of Environmental Protection, State Office Building, 165 Capitol Avenue, Hartford, CT 06106.

FOR FURTHER INFORMATION CONTACT: David B. Conroy, (617) 565-3252; FTS 835-3252 or Lynne A. Hamjain, (617) 565-3246; FTS 835-3246.

SUPPLEMENTARY INFORMATION: On November 19, 1986 (51 FR 41810), EPA published a Notice of Proposed Rulemaking (NPR) for the State of Connecticut. The NPR proposed to approve two new regulations developed and proposed by the State based on EPA's Group III Control Techniques Guideline (CTG) documents. The NPR also proposed to approved amendments to the existing SIP regulation regarding VOC compliance methods for surface coating operations.

The NPR indicated that certain changes to the proposed regulation were necessary for final EPA approval. As outlined below, Connecticut's formally submitted SIP revisions reflect that all of these changes were made to the regulations prior to their final adoption. The State has also made revisions pursuant to public comments received from an affected source during the State's public comment period. The rationale for approving these revisions is presented below.

1. "Control of Volatile Organic Compound Leaks from Synthetic Organic Chemical & Polymer Manufacturing Equipment," Subsection 22a-174-20(x). The regulation requires a VOC leak detection and repair program to be instituted at subject facilities. In the NPR, EPA required Connecticut to include the definition of "In VOC Service," in the regulation to make it consistent with the applicable CTG document, *Control of Volatile Organic Compound Leaks from Synthetic Organic Chemical & Polymer Manufacturing Equipment* (EPA-450/3-83-006). The State defined this term in the finally adopted regulation, and, therefore, the regulation is now fully approvable.

The State also made changes to the proposed version of this regulation pursuant to a public comment received from an affected facility. These changes

add monitoring exemptions to the final version of the regulation. The final regulation does not require quarterly monitoring of safety relief valves that are isolated by a frangible disk or rupture disk; it does, however, require that these configurations be monitored annually in case the disk is improperly situated or has corroded. Additionally, the final regulation exempts canned pumps that have demonstrated compliance with 40 CFR 60.482-2 (e)(2) and (e)(3) from quarterly monitoring and visual weekly inspections. These exemptions are consistent with the New Source Performance Standard (NSPS) for this industry titled, "Standards of Performance for Equipment Leaks of VOC in the Synthetic Organic Chemicals Manufacturing Industry." (40 CFR Part 60, Subpart VV.)

Final Action: EPA is approving the addition of subsection 22a-174-20(x), "Control of Volatile Organic Compound Leaks from Synthetic Organic Chemical & Polymer Manufacturing Equipment," as a revision to the Connecticut SIP because it is consistent with the CTG document for this source category.

2. "Manufacture of Polystyrene Resins," Subsection 22a-174-20(y). This regulation requires all continuous polystyrene resin manufacturing facilities to comply with an emission limit of 0.12 kg of VOC/1,000 kg of product in total from the styrene condenser vent and the styrene recovery unit condenser vent. EPA finds this regulation consistent with the CTG document *Control of Volatile Organic Compounds Emissions from Manufacture of High-Density Polyethylene, Polypropylene, and Polystyrene Resins* (EPA-450/3-83-008). This regulation does not address polypropylene and high-density polyethylene manufacturers. On May 29, 1987, the Connecticut DEP submitted a letter, pursuant to an EPA request, certifying that there are no sources of these types in the State. Therefore, it is not necessary for Connecticut to adopt a regulation covering these types of facilities. If such a facility did locate in the State of Connecticut at some point in the future, it would be covered at a minimum under the NSPS entitled, "Standards of Performance for New Stationary Sources; Polypropylene, Polyethylene, Polystyrene, and Poly(ethylene terephthalate) Manufacturing Industry." (40 CFR Part 60, Subpart DDD.) This NSPS was proposed for approval by EPA on September 30, 1987 (52 FR 36678).

The DEP made one change to the proposed version of this regulation pursuant to public comments received during its public comment period. Under

subdivision 22a-174-20(y)(6), "Test Methods," the State has added an emission rate equation to the finally-adopted regulation for use with EPA Reference Method 18. In the proposed version of the regulation, the emission rate equation could only be used with EPA Reference Method 25. The additional use of the emission rate equation in the final version of the regulation is approvable because the EPA-recommended test methods for this CTG category are Methods 18, 25, or 25A.

Final Action: EPA is approving the addition of subsection 22a-174-20(y), "Manufacture of Polystyrene Resins" as a revision to the Connecticut SIP because it is consistent with the CTG document for this source category.

3. "VOC Compliance Methods," Subsection 22a-174-20(bb). This regulation is being amended to clarify that VOC surface coating sources are required to use a capture system with a 90% collection efficiency when utilizing add-on control equipment to achieve compliance. Pursuant to a request by EPA, the State has also clarified the applicability of this regulation. In Connecticut's proposed version of the amendments, subsection 22a-174-20(bb) was inadvertently listed as applicable to the following subsections: subsection 22a-174-20(t), "Manufacture of Synthesized Pharmaceutical Products," subsection 22a-174-20(u), "Manufacture of Pneumatic Rubber Tires," and subsection 22a-174-20(v), "Graphic Arts Rotogravers and Flexography." These regulations already contain capture and control efficiency requirements within them. The State has removed these subsections from the applicability paragraph of subsection 22a-174-20(bb) in the final by adopted version of the amendments to this regulation.

Final Action: EPA is approving revisions to subsection 22a-174-20(bb), "VOC Compliance Methods," of the Connecticut SIP.

Additionally, the Connecticut DEP submitted a letter to EPA on July 3, 1986 clarifying the testing requirements in section 22a-174-5 "Methods for Sampling Emission Testing, and Reporting," of its regulations. In this letter, the DEP commits to requiring only EPA-approved test methods when requiring emission testing of sources of VOC emissions. This letter has been provided to EPA to clarify the DEP's implementation of section 22a-174-5.

The Office of Management and Budget has exempted this rule from the requirements of section 3 of Executive Order 12291.

Under section 307(b)(1) of the Act, petitions for judicial review of this action must be filed in the United States Court of Appeals for the appropriate circuit by July 18, 1988. This action may not be challenged later in the proceedings to enforce its requirements. (See 307(b)(2).)

List of Subjects in 40 CFR Part 52

Air pollution control, Hydrocarbons, Incorporation by reference, Intergovernmental relations, Ozone, Reporting and recordkeeping requirements.

Note.—Incorporation by reference of the State Implementation Plan for the State of Connecticut was approved by the Director of the Federal Register on July 1, 1982.

Date: May 1, 1988.

Lee M. Thomas,
Administrator.

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

PART 52—[AMENDED]

Subpart H—Connecticut

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

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

2. Section 52.370 is amended by adding paragraph (c)(38) as follows:

§ 52.370 Identification of plan.

(c) * * *

(38) Revisions to the State Implementation Plan were submitted by the Connecticut Department of Environmental Protection (DEP) on April 14, 1987.

(i) *Incorporation by reference.* (A) Letter dated April 14, 1987 from the Connecticut Department of Environmental Protection submitting revisions to the State Implementation Plan for EPA approval.

(B) Letter dated April 1, 1987 from the Secretary of State of Connecticut to EPA.

(C) Section 22a-174-20(x) of Connecticut's Regulations for the Abatement of Air Pollution titled, "Control of Volatile Organic Compound Leaks from Synthetic Organic Chemical & Polymer Manufacturing Equipment," effective April 1, 1987.

(D) Section 22a-174-20(y) of Connecticut's Regulations for the Abatement of Air Pollution titled, "Manufacture of Polystyrene Resins," effective April 1, 1987.

(E) Amendments to subsection 22a-174-20(bb) of Connecticut's Regulations for the Abatement of Air Pollution titled,

"Compliance Methods," effective April 1, 1987.

(ii) *Additional materials.* (A) Letter from the Connecticut DEP dated July 3, 1986 committing the Connecticut DEP to use only EPA approved test methods when requiring the testing of sources emitting volatile organic compound emissions.

(B) Letter from the Connecticut DEP dated May 29, 1987 certifying that there are no polypropylene or high-density polyethylene manufacturers in the State of Connecticut.

3. Section 52.375 is amended by adding paragraph (d) as follows:

§ 52.375 Certification of no sources.

(d) Manufacturers of High-density Polyethylene and Polypropylene Resins.

[FR Doc. 88-10077 Filed 5-18-88; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Part 421

[BPO-057-F]

Medicare Program; Assignment and Reassignment of Provider-Based Home Health Agencies and Hospices To Designated Regional Intermediaries

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

ACTION: Final rule.

SUMMARY: We are modifying Medicare regulations to assign provider-based home health agencies, provider-based hospices and all new freestanding hospices to regional intermediaries designated by HCFA.

EFFECTIVE DATE: These regulations are effective June 20, 1988.

FOR FURTHER INFORMATION CONTACT: Norman Fairhurst: Regarding transition issues, (301) 594-9498; Toba M. Winston: Regarding intermediary designation (301) 597-0471.

SUPPLEMENTARY INFORMATION:

I. Background

A. General

In the Medicare program, in general, intermediaries under contract with HCFA are responsible for making payment to providers of services for the covered services they furnish to Medicare beneficiaries.

Section 1816 of the Social Security Act permits any group or association of providers to nominate an intermediary to determine the proper amount of reimbursement and to make that reimbursement. As amended in 1977, this section authorized the Secretary to assign and reassign providers that had nominated intermediaries to other intermediaries, and to designate regional or national intermediaries for a class or classes of providers, if he determines that to do so would result in the more effective and efficient administration of the program (section 1816(e) of the Act).

B. Home Health Agencies

1. Background

Section 1816(e)(4) of the Act requires the Secretary to assign home health agencies to designated regional intermediaries, except that he may assign a home health agency (HHA) that is a subdivision of a hospital (and that agency and hospital are affiliated or under common control) only if, after applying criteria relating to administrative efficiency and effectiveness as he has promulgated, he determines that to do so would result in more effective and efficient administration of the Medicare program.

To implement the provisions of section 1816(e)(4) of the Act, we amended our regulations (42 CFR 421.117) to require that all freestanding HHAs served by a nominated intermediary be served instead by a regional intermediary designated by HCFA (47 FR 38535, September 1, 1982). At that time, in the preamble to those amendments, we defined "regional" as meaning "State" and we designated one intermediary to serve freestanding HHAs in each State. We also amended our regulations (42 CFR 421.103) concerning providers' options to elect to receive payments directly from HCFA rather than through an intermediary (49 FR 3638, January 30, 1984). These regulations clarified our authority to contract out the workload of HHAs that dealt directly with us instead of through intermediaries. Effective February 29, 1984, we required the direct dealing freestanding HHAs to receive payments from the designated regional intermediaries. In addition, we made available to HHAs the option of requesting an alternative designated intermediary if the HHA could demonstrate that such an arrangement would be consistent with the effective and efficient administration of the Medicare program. (42 CFR 421.117 (e), (f) and (g), 47 FR 3660, January 30, 1984).

As a result of these revisions, all freestanding HHAs were assigned to designated regional intermediaries. Provider-based HHAs were not affected by these revisions and continued to be served by the intermediaries serving the parent providers.

In 1984, Congress amended section 1816(e)(4) of the Act (section 2326 of Pub. L. 98-369) to require that, by not later than July 1, 1987, HCFA reduce the number of designated regional home health intermediaries to not more than ten. Accordingly, on February 13, 1986, we published a final notice designating ten regional intermediaries to serve freestanding home health agencies (51 FR 5403).

(See below for a listing of the designated intermediaries and their service areas.)

2. Proposed Rule Related to HHAs

On January 22, 1987, we published a proposed rule announcing our intent to assign provider-based HHAs to the same intermediaries designated for freestanding HHAs (52 FR 2424).

With respect to a hospital-based HHAs, section 1816(e)(4) of the Act states that the Secretary shall assign hospital-based HHAs to designated intermediaries only if, after applying criteria relating to administrative efficiency and effectiveness as the Secretary may promulgate, it is determined that such assignment would result in the more effective and efficient administration of the Medicare program. We proposed to modify 42 CFR 421.117 to establish criteria that are applicable to this issue and determined, based on the application of the criteria listed and discussed below, that the assignment of hospital-based HHAs to designated regional intermediaries could be expected to result in more effective and efficient administration of the program. Additionally, although not required to do so, we also determined based on the application of these criteria, that the assignment of HHAs that are based in a Medicare provider other than a hospital (e.g., based in a Medicare skilled nursing facility) could also be expected to result in more effective and efficient administration of the program.

The six specific criteria we used to determine whether to assign provider-based HHAs to the ten regional intermediaries are as follows:

a. Uniform interpretation of Medicare rules—Assignment of provider-based HHAs to designated regional intermediaries must facilitate uniformity in interpreting Medicare rules.

b. Expertise in bill processing—Assignment of provider-based HHAs to designated regional intermediaries must

ensure that HHA bills are processed by an intermediary with expertise in processing and adjudicating home health bills.

c. Control of administrative costs—Assignment of provider-based HHAs to designated intermediaries must have the potential to reduce administrative costs.

d. Ease of communication with HHAs—Assignment of provider-based HHAs to designated regional intermediaries must facilitate communication of program policy and issues.

e. Ease of data collection—Assignment of provider-based HHAs to designated regional intermediaries must facilitate data collection.

f. Ease of HCFA monitoring of intermediary performance—Assignment of provider-based HHAs to designated regional intermediaries must facilitate HCFA's monitoring of intermediary performance.

We also proposed that the Secretary could use other criteria he believes to be pertinent.

All of the criteria except item b above are met simply by virtue of transferring all HHA providers to the ten intermediaries. For example, it is more efficient and less costly to send out ten sets of instructions rather than more, to collect data from ten intermediaries, than to collect it from more, or to make data processing systems changes at ten intermediaries rather than more.

While it is not as evident that criterion b has been met, we were confident that it would be. We proposed to transfer HHAs to intermediaries whose long-term overall performance indicates they are effective and efficient and we believed that once the HHAs were transferred to the designated intermediaries, performance data would substantiate the accuracy of our projection.

We proposed that the intermediaries designated to serve the provider-based HHAs be the same intermediaries currently designated to serve the freestanding HHAs.

These intermediaries and the areas they serve are:

a. Associated Hospital Service of Maine—Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island and Vermont.

b.¹ The Prudential Insurance Company of America—New Jersey, New York, Puerto Rico and the Virgin Islands.

¹ Note.—The Prudential Insurance Company of America notified the Health Care Financing Administration on April 20, 1988 that it intends to terminate its Medicare contracts effective December 31, 1988. Those home health agencies and hospices that were to be or are currently served by

c. Blue Cross of Greater Philadelphia—Delaware, District of Columbia, Maryland, Pennsylvania, Virginia and West Virginia.

d. Blue Cross and Blue Shield of South Carolina—Kentucky, North Carolina, South Carolina and Tennessee.

e. Aetna Life and Casualty—Alabama, Florida, Georgia and Mississippi.

f. Blue Cross and Blue Shield United of Wisconsin—Wisconsin, Michigan and Minnesota.

g. Health Care Service Corporation (Chicago, Illinois)—Illinois, Indiana and Ohio.

h. New Mexico Blue Cross and Blue Shield, Inc.—Arkansas, Louisiana, New Mexico, Oklahoma and Texas.

i. Blue Cross of Iowa, Inc.—Colorado, Iowa, Kansas, Missouri, Montana, Nebraska, North Dakota, South Dakota, Utah and Wyoming.

j. Blue Cross of California—Alaska, Arizona, California, Hawaii, Idaho, Oregon, Nevada and Washington.

We also proposed granting provider-based HHAs the same opportunity afforded freestanding HHAs to request to be served by an alternative designated regional intermediary. These requests were not to be granted automatically; rather an HHA would be required to demonstrate that the change to the alternative designated regional intermediary would be consistent with the effective and efficient administration of the Medicare program. The requests would have to be filed in accordance with the timetable established at 42 CFR 421.106(a) and would be evaluated in accordance with criteria contained at 42 CFR 421.106(b). The intermediaries we proposed designating as alternative designated intermediaries for provider-based HHAs and the areas in which they would be available are:

The Prudential Insurance Company of America—Alabama, Connecticut, Delaware, District of Columbia, Florida, Georgia, Iowa, Kansas, Kentucky, Maine, Maryland, Massachusetts, Mississippi, Missouri, Nebraska, New Hampshire, North Carolina, Pennsylvania, Rhode Island, South Carolina, Tennessee, Vermont, Virginia, and West Virginia;

Blue Cross of Iowa, Inc.—Alaska, Arizona, Arkansas, California, Hawaii, Idaho, Illinois, Indiana, Louisiana, Michigan, Minnesota, Nevada, New Jersey, New Mexico, New York, Ohio, Oklahoma, Oregon, Puerto Rico, Texas, Virgin Islands, Washington and Wisconsin; and

Prudential will be notified of their servicing intermediary as soon as a replacement for Prudential is selected.

Blue Cross of California—Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming.

In proposing to assign provider-based HHAs to the designated intermediaries, we proposed that where the HHA and parent provider would be served by different intermediaries that audit and cost report settlement for both remain the responsibility of the intermediary serving the parent provider. Bill processing, making coverage determinations and making payments to the HHA would be done by the designated regional intermediary.

C. Hospices

1. Background

Section 1816(e)(5) of the Act requires the Secretary to designate the intermediary that will serve each hospice, except that with respect to a hospice that is a subdivision of another Medicare provider (and the hospice and parent provider are under common control) due regard be given to the intermediary serving the parent provider.

To implement the provisions of section 1816(e)(5), we amended our regulations at 42 CFR 421.117 to require that (1) freestanding hospices receive payment through an intermediary designated by HCFA; (2) hospices that are subdivisions of another Medicare provider that elected to receive payments through an intermediary receive payment through the same intermediary that serves the parent provider; and (3) hospices that are subdivisions of another Medicare provider that elected to deal directly with HCFA receive payment through an intermediary designated by HCFA. (48 FR 56036, December 16, 1983).

Currently two intermediaries are designated to serve freestanding hospices and provider-based hospices in category (3) above. The Prudential Insurance Company of America serves hospices located in States east of the Mississippi River and Blue Cross of California serves hospices located in States west of the Mississippi River. The entire States of Minnesota and Louisiana are served by Blue Cross of California.

2. Proposed Rule Related to Hospices

In the proposed rule published on January 22, 1987, we announced our intent to amend current regulations at 42 CFR 421.117(c) to assign provider-based hospices and all newly participating freestanding hospices to the designated regional intermediaries serving HHAs. Thus, we planned to expand from two to ten the number of intermediaries

designated to serve freestanding hospices. We pointed out that while we had previously designated two intermediaries to serve freestanding hospices, this had not resulted in a concentration of the workload because there are many intermediaries processing small provider-based hospice workloads. We also pointed out that existing regulations require that provider-based hospices be served by the same intermediary serving the parent provider. Since the majority of hospices are based in HHAs, an indirect result of the assignment of freestanding HHAs to the ten designated intermediaries was a concentration of the hospice workload in these ten intermediaries. We believe it makes sense to make this concentration complete. Therefore, we proposed that the intermediaries designated to serve hospices be those same intermediaries designated to serve HHAs. In the case of provider-based hospices, we proposed that the settlement of the Medicare cost report, including the supplemental hospice worksheets, continue to be the responsibility of the intermediary serving the parent provider.

We proposed assigning newly-participating freestanding hospices to the intermediary designated for its location.

In the interest of minimizing disruptions, we proposed an exception to the general rule in order to allow those freestanding hospices currently served by Prudential or Blue Cross of California to continue to be served by those intermediaries, if the hospice so desired.

We also proposed granting a hospice the opportunity to request to be served by an alternative designated regional intermediary if it demonstrated that the change to the alternative designated regional intermediary would be consistent with the effective and efficient administration of the Medicare program. Such requests would have to be filed in accordance with the timetable established at 42 CFR 421.106(a) and would be evaluated in accordance with criteria contained at 42 CFR 421.106(b). We proposed that the alternative designated regional intermediaries and the areas in which they would be available be the same as those listed above for HHAs.

We made the above proposal in the interest of achieving greater effectiveness and efficiency in administering the Medicare hospice benefit. We proposed that the criteria relating to effective and efficient administration listed above in connection with HHAs also apply to the designation of intermediaries for

hospices. Additionally, reassignment of the provider-based hospices would not have a negative impact on the intermediaries currently serving them. Very few hospice providers would be eliminated from an intermediary's current list of providers. In the majority of cases, only one hospice would be eliminated from the list. A loss of so few providers would not have a detrimental effect on the involved intermediaries.

D. Technical revisions.

We proposed making the following technical changes:

- Amending the definition of "Intermediary" at 42 CFR 421.3, by changing the term "freestanding HHAs" to "HHAs" to clarify that we have designated intermediaries for all HHAs.

- Deleting the clause "Except for certain hospice physician services, which are generally reimbursed by carriers" from 42 CFR 405.117(c) (redesignated as 42 CFR 405.117(d)). Carriers have never reimbursed hospice physician services, so this clause is inaccurate.

- Deleting 42 CFR 421.117(g) (redesignated as 42 CFR 421.117(h)), which gave freestanding providers dealing directly with HCFA 30 days from January 30, 1984 to request transfer to the alternative designated regional intermediary without having to prove the transfer would result in more effective and efficient administration. Provisions of that paragraph are now obsolete.

- Amending 42 CFR 421.128(f) by deleting the word "freestanding" to show that, under section 1816(e)(4) of the Act, an intermediary that loses either freestanding or provider-based HHAs or hospices as a result of the reassignment or by the designation of regional intermediaries does not have the right to appeal any adverse effect.

II. Analysis and Response to Comments

We received 92 comments: 76 from providers, 7 from provider associations, 6 from Medicare intermediaries, and 1 each from a member of Congress, a State health department, and a county health department. Sixteen of the commenters wrote in support of our proposal; the others objected to the proposal or had concerns with some aspects of the proposal. We discuss the comments and our responses to them below.

Comment: Several commenters, while not disagreeing with the criteria relating to administrative efficiency and effectiveness that we proposed, disagreed that they would be met. Specific comments were (1) it has not

yet been demonstrated that the selected intermediaries have expertise in home health bill processing; (2) until HCFA provides clear guidance of such terms as "skilled nursing," "intermittent care," and "homebound," we will not have consistency in coverage determinations; and (3) savings from economies of scale will be minimal.

Response: Based on our experience with freestanding HHAs, we continue to believe that uniform interpretation of Medicare rules, better control of administrative costs, ease of communication with HHAs, data collection and HCFA monitoring of intermediary's performance will be enhanced by virtue of reducing the number of intermediaries processing provider-based home health bills from 53 to 10. For example, it is more efficient and less costly to work with or issue instructions (or both) to 10 intermediaries than 53. We are better able to monitor performance and collect data from 10 rather than 53 intermediaries to assure there is more uniform interpretation of Medicare rules. We have been monitoring HHA performance data on a monthly basis and where there are issues to be resolved, we are working with the regional office and intermediary staff to resolve these issues.

Regarding criterion b, expertise in bill processing, the designated intermediaries long-term overall performance indicates they have the expertise to adjudicate and process home health bills. Additionally, they have demonstrated the ability to assume a significant increase in workload and continue to process bills accurately and timely. The transfer of freestanding home health agencies to the designated intermediaries was completed September 1, 1987. Approximately 3,000 home health agencies were reassigned. Although a few intermediaries encountered isolated transition problems, the problems were few relative to the magnitude of the task and they have been resolved.

Regarding consistency of coverage determinations, having 10 intermediaries making such decisions is an improvement over having 53 intermediaries making coverage determinations. Furthermore, we have been working with the ten regional intermediaries to identify areas where inconsistent determinations have been made, to arrive at proper determinations, and to see that in the future the guidelines will be applied uniformly.

We agree that savings from economies of scale may be minimal. While we do expect some savings to

accrue from economies of scale in HHA bill processing, we see a large part of the reduced administrative costs coming from having to modify fewer bill processing systems when changes in the home health program require modifications to software programs.

Comment: Several commenters stated that distance from the regional intermediary will create problems. For example, there will be some delays in handling inquiries and there will be additional provider administrative costs, such as long distance telephone calls.

Response: We do not agree that increased distance by itself will create problems. A number of HHA providers at their request are currently assigned to the alternative designated regional intermediary. In many of these cases, the provider is located over 800 miles from the intermediary. This has not created problems. Additionally, for years, many providers, located throughout the United States, elected to be served by HCFA's Office of Direct Reimbursement (ODR). They also did not find distance from ODR to be a problem. While face-to-face provider/intermediary contacts may be less frequent, experience has shown that most issues can be resolved timely and satisfactorily either by telephone or written correspondence.

If the transfer should result in increased provider costs, these costs will be reimbursed according to established Medicare reimbursement principles to the extent they are reasonable, allowable, and verified by the intermediary. If the HHA's costs exceed the limits as the result of the required transfer to a designated regional intermediary, and exception to the limits may be granted to the extent that the costs are reasonable, attributable to the circumstances specified, separately identified by the provider and verified by the intermediary. In the case of hospices, there is no legislative or regulatory basis for exceptions to the rates.

Comment: A couple of commenters stated that transition of provider-based home health agencies to designated intermediaries may mean an initial loss of electronic media claims processing.

Response: The providers will not have to forego the benefits of automation. The designated intermediaries have the capacity to receive HHA bills via various electronic media (tape cassette, disk, dial-up, etc.). Some providers may have to make minor system changes to meet the intermediaries' format and submittal requirements. The designated intermediaries will hold provider training sessions to familiarize the home

health agencies and hospices with their billing requirements.

Comment: Several commenters stated that the ten designated intermediaries have not been in place long enough and requested that we delay the move until we have assessed the effect of the transition of the freestanding home health agencies.

Response: The ten designated intermediaries have a long history of processing home health bills (from the beginning of the Medicare program) and they have further demonstrated their ability in satisfactorily assuming the additional freestanding HHA workload. As we stated previously, over 3000 freestanding home health agencies have transferred to the designated intermediaries. Each intermediary has been able to assume the additional workload, provide orientation and training for the providers, and process bills while maintaining adequate cash flow to providers. The designated intermediaries accomplished this even though, for most of them, the home health workload increased 100 percent or more. We have demonstrated our ability to conduct a smooth transition.

Comment: A commenter with an HHA-based hospice located in a State that is currently served by Aetna has as its intermediary Prudential, because Prudential serves the parent HHA as an alternative designated HHA intermediary. The hospice asked whether it would have to transfer to the intermediary for the State, Aetna. The commenter pointed out that the proposed exception that would allow a hospice currently served by Prudential or California Blue Cross to remain with that intermediary was restricted to freestanding hospices.

Response: We appreciate the commenter calling this situation to our attention. It is our intent that all hospices be assigned to designated intermediaries, but that this be achieved in the least disruptive manner. Therefore, we are allowing any freestanding hospice that is currently assigned to Prudential or Blue Cross of California to continue to be served by that intermediary even if it is not the designated or alternate intermediary for its location. (However, as noted earlier, Prudential does not intend to serve as intermediary after December 31, 1988; its hospices and HHAs will be reassigned by that time.) We will also allow a provider-based hospice currently assigned to any one of the ten designated intermediaries to continue to be served by that intermediary even if it is not the regional or alternate intermediary for its location. Therefore,

the hospice may stay with Prudential if it so chooses.

Although it was not stated in the proposed rule, it is our intention to grandfather in any HHAs in this same situation. We are therefore clarifying the regulations to allow any HHA that is currently served by any one of the designated intermediaries to continue to be served by that intermediary even if it is not the regional or alternate intermediary for its location, if the HHA so chooses.

Comment: Many of the commenters stated that dealing with two intermediaries will be costly and cumbersome and will create confusion. Regarding the latter, the example most often stated was receiving conflicting advice from each intermediary; e.g., regarding preparation of cost reports.

Response: It is true that in some cases providers may need to incur costs for minor computer modifications and personnel training. However, aside from the initial setup expenses, the effect on ongoing costs is expected to be minimal. Costs incurred by the HHA or its parent provider will be reimbursed according to established Medicare reimbursement principles to the extent they are reasonable, allowable, and verified by the intermediary. Hospice rates, on the other hand, are subject to limits and there is no provision for increases beyond the limits even if due to cost increases.

We have taken steps to reduce the possibility of confusion of having two intermediaries serving the provider by assigning each separate, clearly identifiable areas. For example, questions related to fiscal areas such as preparation of cost reports, setting interim rates, audit and cost settlement will be answered by the intermediary serving the "parent" provider. The home health agency or hospice will deal with its designated intermediary regarding all other issues. We will work with intermediaries and providers to make sure that they are informed and clearly understand these divisions of responsibility. Should a question be directed to the inappropriate intermediary (because of the education effort we expect this to be a rare occurrence), that intermediary will not provide an answer, but will refer the question or questioner to the proper intermediary. Therefore, concern that the provider will need to deal with conflicting advice from two intermediaries is unwarranted. We are amending 42 CFR 421.100 to clarify the delineated responsibilities for service to provider-based hospices and HHAs.

Comment: A couple of commenters suggested that they should have access

to toll-free 800 numbers to the designated intermediaries.

Response: We are not considering the establishment of toll-free telephone lines. The costs of provider telephone calls continue to be included in the HHA's cost report as a normal business expense and are reimbursable under established Medicare reimbursement principles.

Comment: One commenter stated that providers are being deprived of their right to a choice of intermediary.

Response: In the case of home health agencies and hospices, the right of a provider to choose its intermediary is limited by statute (sections 1816(e)(4) and 1816(e)(5) of the Act). Under this rule HHAs retain the same right other providers have to request a change of intermediary; i.e., they may request a change to the alternative designated intermediary. As in the case of other providers, we will evaluate any such request based on criteria at 42 CFR 421.106. An exception is provided for a hospice or HHA that as of [the effective date of this rule] is receiving payment from any one of the ten designated regional intermediaries. Such a hospice or HHA may, if it so desires, continue to receive payment from that intermediary even if that intermediary is not the designated regional intermediary or the alternative designated regional intermediary for the particular State in which the hospice or HHA is located.

Comment: A few commenters questioned our objectivity in selecting the designated intermediaries. Some quoted the General Accounting Office (GAO) report, "Need to Strengthen Home Health Care Payment Control and Address Unmet Needs", (GAO/HRD-87-9) that stated that information we used in the selection process raised questions about the prior performance of all 47 intermediaries assessed, including the 10 selected to serve as regional intermediaries.

Response: In making selections of the 10 regional intermediaries, we engaged in a public process to allow input from all interested parties. We published a proposed notice (50 FR 14162) on April 10, 1985, with a 60 day comment period announcing this initiative. On February 13, 1986, after an analysis of all comments received, we published a final notice (51 FR 5403). To summarize what is explained in detail in those notices: in the selection process, we considered the distribution of providers and workload, transition risks, and each intermediary's performance against an entire array of criteria as compared with other existing intermediaries available within the proposed regional configurations. We evaluated each intermediary's

performance specific to serving HHAs, their electronic data processing capability and past performance as measured by HCFA's fiscal year 1983 and 1984 Contractor Performance Evaluation Program (CPEP).

With respect to the GAO report, we note that GAO criticism of our selection relied heavily on data related to denials. As we stated in the February 13, 1986 final notice, we did not use denial rates in our analysis because denial rates are subject to ambiguous interpretation. For example, it is not clear to what extent low denial rates are related to good provider education efforts by intermediaries or overly broad interpretations of existing coverage policy.

Comment: A number of commenters were concerned that the transition could disrupt cash flow to the provider-based agencies.

Response: We will make every effort to assure that there will be no interruption of cash flow. Before the transition, we will identify each home health agency, its method of reimbursement and its frequency of receiving that reimbursement so that we can identify potential problem areas. As we have done in the past transitions, we will work closely with the intermediaries and affected providers to resolve problems that could interrupt cash flow. Additionally, we will use existing payment procedures to meet provider cash flow requirements under special circumstances. The reassignment of freestanding HHAs was completed September 1, 1987. Approximately 3,000 HHAs were transferred. The transfers went well; no major problems occurred. We promptly addressed and settled issues raised.

Comment: One commenter stated that since the regional intermediary is used to dealing with proprietary agencies only, it will not understand the special needs and functions of a hospital-based agency.

Response: Our designated intermediaries serve all types of home health agencies within their service area. These include, in addition to proprietary agencies, visiting nurse association agencies, combined government and voluntary agencies, official health agencies, private non-profit agencies, rehabilitative facility-based agencies and hospital-based and skilled nursing facility-based agencies. Each intermediary is aware of and able to accommodate the unique features and special needs of each type of agency to the extent appropriate to do so.

Comment: Several commenters expressed the opinion that there could

be problems in the timely exchange of remittance and utilization information between the designated intermediary and the local intermediary. These commenters were concerned about how this would effect setting interim rates.

Response: Separating the claim processing and fiscal functions will require coordination between the two intermediaries. The intermediary serving the parent provider will need utilization data from the regional intermediary in order to establish and adjust interim rates.

We are working to identify data exchange needs and establish time frames for exchange of those data. This procedure will be in place before we begin transfer of provider-based HHAs. Since the designated intermediary is also a local intermediary for hospitals in its own State, it is aware of the need for prompt and accurate Provider Statistical and Reimbursement (PS & R) reports.

Comment: A substantial number of commenters stated that they have had a good working relationship with their current intermediary and some questioned whether this type of relationship will continue.

Response: We are pleased to hear that providers have been satisfied with the service given by their current intermediaries. The designated intermediaries and we will do everything possible to facilitate the formation of new, effective working relationships with the providers that are transferred. To illustrate, designated intermediaries have held nearly 700 workshops for providers reassigned to them. These workshops will continue with the reassignment of the provider-based HHAs. In addition, a HCFA ombudsman is available in each HCFA region to help solve any problems which may arise.

Comment: A few commenters stated that the current regional home health intermediaries are overburdened and are not processing claims timely. Some questioned whether the intermediaries can absorb the additional workload.

Response: Eight out of the ten designated regional intermediaries are meeting or exceeding the Congressional standard for timely HHA bill processing (95 percent of clean claims must be paid within 30 days of receipt). Of the two remaining intermediaries, one is very near this standard (based on data for September 1987) and the other is experiencing problems unrelated to the absorption of the freestanding HHA workload. The intermediary has taken steps to correct the problem and improvement in timely HHA bill processing is anticipated shortly.

Regarding absorption of the provider-based HHA workload, as we did for the freestanding HHA transition, HCFA will ask each designated intermediary to submit a plan which details the measures it will take; i.e., the number, location, and frequency of provider training workshops and the hiring and training of additional staff needed to accommodate this workload successfully. We will carefully review each plan to ensure that each designated intermediary will have the capability to process home health bills timely and correctly without disruption of service to providers.

Comment: A few commenters thought that the change to designated intermediaries would be confusing for beneficiaries.

Response: Claims for home health services are submitted to the intermediaries by the providers and reimbursement is made directly to the providers. Generally, beneficiaries communicate with intermediaries only when they request a reconsideration or an appeal of a decision. In those instances, they will have a written decision from the intermediary who processed the claim and will therefore know where they should direct their request.

Comment: One commenter stated that it is inappropriate to allow providers to request and be served by an alternative regional intermediary. The commenter pointed out that it is contrary to the goal of consistency in coverage determinations to allow home health providers in the same State to have different regional intermediaries.

Response: We agree that the ideal situation, with respect to consistency, would be to have only a single intermediary serving home health agencies within a given location. However, as administrator of a national program we also wish to treat all classes of providers fairly and grant them the same privileges, insofar as possible. Therefore, we think it is appropriate to maintain the ability to request a change of intermediary. This policy is consistent with existing regulations at 42 CFR 421.106(b), which empowers us to permit a provider to change to another intermediary if we conclude that such change is in the best interest of the Medicare program.

Comment: One commenter stated that our interpretation of when a request to be served by the alternative designated regional intermediary is in the best interests of effective and efficient administration of the Medicare program has become more restrictive over the past twelve months. The commenter felt we should provide more detailed

instructions on the criteria that will be used to determine assignment to the alternative designated regional intermediary.

Response: The right of a home health agency to request to be served by an alternative intermediary was first established by 42 CFR 421.117 when we reduced the number of HHAs dealing directly with HCFA. At that time, HHAs that were served by HCFA's Office of Direct Reimbursement and that did not wish to be served by the designated regional intermediary were given the opportunity to elect to be served by the alternative designated intermediary. Freestanding HHAs that were served by intermediaries were given the opportunity to request a change to the alternative intermediary. However, in the case of these HHAs served by intermediaries, such requests were not to be granted automatically. These HHAs were required to demonstrate that the change to the alternative intermediary would be consistent with the effective and efficient administration of the Medicare program.

The policy relative to granting approval for use of the alternative intermediary can be misinterpreted so that one might believe a request to change intermediaries would be automatically granted. We would like to state clearly in this preamble that no request for a change in intermediary will be granted without sufficient development. The policy as established by 42 CFR 421.117 (f) and (g) is still effective and is not being changed by this rule.

It should be noted, however, that a hospice or an HHA that as of June 20, 1988 is served by one of the ten designated intermediaries may continue, if it so desires, to be served by that intermediary even if that intermediary is not the designated regional intermediary or the alternative designated regional intermediary for the particular State in which the hospice or HHA is located. This exception is established by this rule at 42 CFR 421.117(h).

Our rules at 42 CFR 421.117 (f) and (g) reflect our desire to accommodate a provider faced with a totally unacceptable situation (such as, but clearly not limited to, a conflict of interest situation) that would preclude acceptable operational efficiencies being realized by the Medicare program, were the HHA required to remain with the designated regional intermediary. In those cases where an HHA or an HHA chain desires to be served by the alternative intermediary, and in the absence of a clearly unacceptable situation, such as the demonstrable

conflict of interest situation, we fully expect the HHA to quantify the operational advantages specifically to be realized by the Medicare program as well as any advantages that accrue to the agency. We will examine, in order to verify, the reported benefits to the Medicare program before we approve any request for transfer to any alternative intermediary. We will decide each case on an individual basis and on its own merits.

Comment: One commenter, a Medicare-participating health maintenance organization (HMO) with a Medicare-certified HHA, stated that it currently submits a UB-82 form on each home health patient as a "no-pay" claim so that Medicare will have a record of the services. The commenter raised two points. First, this HMO was concerned that information regarding its practice patterns would be going to an intermediary which competes with it in the marketplace, giving the intermediary a competitive advantage. Second, the commenter pointed out that since the designated intermediary would not make coverage determinations, but would only forward the no-pay bill data to HCFA, the significant advantages that will accrue from more uniform interpretation of coverage policy will not apply to HMOs. The commenter suggested we, therefore, consider an exception to the assignment to the designated intermediary.

Response: An HMO is no longer required to submit "no-pay" bills for services provided by its HHA. The HMO community was informed informally of this some time ago and this change will be formalized by revised instructions in the HMO and HHA Manuals. This resolves both of the above issues. First, the potential for the intermediary to gain a competitive advantage is eliminated since data will not be submitted to the designated intermediary. (Note: The Medicare intermediary agreement prohibits the intermediary from using either its position as a Medicare contractor or information it obtains in performing its functions as a Medicare contractor for purposes of furthering its private business interests or gain.) Second, it is not necessary to make an exception in the regulations, since the assignment of the HMO-based HHA will be, in effect, merely a "paper" tie-in. Because the provider need not submit any claims or data to the intermediary, the tie-in will have no effect on the provider's operation.

Comment: One commenter, a statewide hospital association commenting on behalf of its membership, stated that as a general

policy it believes it is unwise to create specialized intermediaries for each service covered under the Medicare program.

Response: We agree there should not be a general policy to have specialized intermediaries for all Part A services. Each covered service needs to be evaluated individually to determine whether specialized intermediaries are desirable. In the case of the home health and hospice benefits, designation of intermediaries was legislatively mandated for such freestanding facilities. We have evaluated the situation and have concluded that it is efficient and effective to treat provider-based home health agencies and hospices in the same manner.

Comment: A Medicare intermediary suggested that we also transfer the provider-based rural health clinics (RHCs) to the intermediaries designated to serve the freestanding RHCs.

Response: As stated in the previous response, each service needs to be evaluated individually. In 1985, HCFA staff did an analysis concerning specialization of RHCs and at that time recommended against specializing the provider-based RHC workload. We appreciate the commenter's interest in improving the Medicare program but we are not adopting this comment.

Comment: One commenter stated that Mississippi Blue Cross' loss of the HHA workload would deprive the State of Mississippi of needed revenue.

Response: Although Mississippi Blue Cross is losing the provider-based home health and hospice workloads in terms of bill processing, it is retaining responsibility for all fiscal functions such as audit and settlement of cost reports for these providers. Based on historical patterns, we expect the reduction in HHA and hospice bill volume will be mostly offset by an increase in the volume of other bill types. The slight decrease in the workload of one organization should have imperceptible consequences for the state economy.

Comment: Two commenters stated that chain providers should be exempt from these regulations. They did not give specific rationale.

Response: Section 1816(e)(4) of the Act does not permit exemption for chain providers from the requirement that they be served by designated intermediaries. We recognize that there may be cases in which the degree of centralization of the chain would make it more efficient for the chain to be served by a single intermediary. Therefore, a chain may, in accordance with proposed 42 CFR 421.117(e), request to be served by a

single intermediary. We will evaluate such a request in accordance with criteria contained at 42 CFR 421.106.

Comment: A Medicare intermediary commented that if the proposal were adopted and if the CPEP standards remain consistent for FY 1988, our proposed reassignment could jeopardize the intermediary's ability to pass CPEP.

Response: This initiative should not adversely affect intermediary performance; rather, we anticipate a greater ability to sustain or improve current performance. We do, however, recognize that there are differing responsibilities between the intermediary serving the parent provider and the designated regional intermediary. It is possible that one of these intermediaries could be adversely affected by some action or inaction of the other. As spelled out in CPEP, if a condition exists that adversely affects an intermediary's performance and that is outside of that intermediary's control, we will assess the adverse circumstances and make appropriate adjustments in performance measures.

Comment: One commenter questioned our reason for going to ten designated intermediaries for hospices rather than staying with the two currently designated to serve the freestanding hospices. The commenter stated the belief that the growth of the certified hospice movement is questionable.

Response: Increasing the number of intermediaries designated to serve hospices was not based solely on the number of hospice providers (128 freestanding, 275 provider-based, as of September 1, 1987). We agree that this workload could be handled by two intermediaries. However, one of our goals is to minimize disruption among the hospice providers. Regulations in effect at the time we designated the ten regional intermediaries for freestanding home health agencies required that hospices be served by the intermediary serving the parent provider. Since approximately 65 percent of the provider-based hospices were based in freestanding home health agencies, an indirect result of the HHA intermediary designation was a concentration of the provider-based hospices in the ten designated HHA intermediaries. We did not want to require these hospices, which had recently transferred along with the parent home health agency, to transfer to a new intermediary again.

Comment: One commenter recommended that if a hospital has both an affiliated home health agency and hospice, their transfer to the designated intermediary should coincide.

Response: We agree; they will be transferred at the same time.

III. Provisions of the Final Rule

We are adopting in final, with minor technical changes to correct typographical errors, the rules as proposed on January 22, 1987. As proposed, we are amending our regulations at 42 CFR 421.117 so that all HHAs and hospices are to be assigned to designated regional intermediaries. (See section B.2. of the Background for a listing of these intermediaries and their service areas.)

As proposed, we are granting all HHAs and hospices the right to request to be assigned to an alternative designated intermediary. We will not grant these requests automatically; the provider must demonstrate that the change would be consistent with the effective and efficient administration of the Medicare program. The request must be filed in accordance with the timetable established at 42 CFR 421.106(a) and will be evaluated in accordance with criteria contained at § 421.106(b). (See section B.2. of the Background for a listing of the alternative designated intermediaries and the areas in which they will be available.)

We are amending regulations at 42 CFR 421.100 to delineate clearly in regulations the responsibilities for service to provider-based HHAs and provider-based hospices. Where the HHA or hospice and its parent provider will be served by different intermediaries, the designated regional intermediary will process bills, make coverage determinations and make payments to the HHAs and hospices. The intermediary serving the parent provider will perform all fiscal functions, including audits and settlement of the Medicare cost reports and the HHA and hospice supplement worksheets.

The proposed rule allowed any freestanding hospice to continue to be served by Prudential or Blue Cross of California, if it so wished. As explained in the "Comment" section, we are expanding this exception so that any hospice or HHA that is currently served by a designated regional intermediary or alternative designated regional intermediary also may remain with that intermediary.

We are adopting the technical changes as proposed.

IV. Implementation Activities

We expect approximately 1,200 provider-based HHAs and approximately 80 provider-based

hospices to be reassigned to another intermediary under this proposal.

A. Notification to Providers

We will send a notice to each affected HHA and hospice, advising it of the name of its designated regional intermediary and the scheduled change-over date for bill submittals.

B. Transfer Schedule

Providers will receive at least a 60-day advance notice before the date of the change-over. Fiscal functions will remain the responsibility of the intermediary serving the parent provider. Consequently, transfers need not be based on the provider cost report year ending date. The reassignment of all affected HHAs and hospices is expected to be completed within 6 months.

C. Procedures During the Change-Over Period

We will notify each affected HHA and hospice by mail of procedures to follow during the change-over process. We are arranging for an orderly transition of service.

1. HHAs and hospices will submit bills for services provided before the change-over date to the current intermediary. This same intermediary will continue to be responsible for the settlement of cost reports, prior unsettled cost reports, any appeals arising from those cost reports, and all other fiscal issues.

2. The HHAs and hospices will submit all bills for services provided on and after the change-over date to the designated intermediary.

3. We are continuing ombudsman-type positions established in each HCFA regional office to assist providers in resolving any problems encountered during the transition or thereafter.

D. Assurance of Cash Flow

We will make every effort to assure that there will be no interruption of cash flow to HHAs or hospices. We will work closely with the designated intermediary, HHAs and hospices to identify and resolve problems that might interrupt the provider's cash flow.

E. Transition Costs

HHA costs incurred due to the transfer will be allowable and reimbursable under established Medicare reimbursement principles. If the HHA's costs exceed the limits as the result of the required transfer to a designated regional intermediary, we will grant an exception to the limits, to the extent that the costs are reasonable, attributable to the circumstances

specified, separately identified by the provider and verified by the intermediary. We will process requests for transition cost exceptions consistent with the provisions for handling other exceptions requested under 42 CFR 413.30(f)(2).

In the case of hospices, there is no legislative or regulatory basis for exceptions to the rates.

Regulatory Impact Statement

A. Executive Order No. 12291

Executive Order No. 12291 requires us to prepare and publish an initial regulatory impact analysis for any regulations that are likely to meet criteria for a "major rule".

A major rule is one that would result in:

- (1) an annual effect on the economy of \$100 million or more;
- (2) a major increase in costs or prices for consumers, individual industries, Federal, State, or local government agencies, or any geographic regions; or
- (3) 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.

This document contains our description of how we will interpret and implement sections 1816(e) (4) and (5) of the Act. We believe it is not a rule subject to the Executive Order. Nevertheless, in the spirit of the Executive Order, we are voluntarily providing the following information.

We project that, under our proposal, 1,200 provider-based HHAs and approximately 80 provider-based hospices will be reassigned from their present intermediary to a different intermediary. We project that we will incur one-time administrative costs of \$2 million for travel and training related to the reassignment of these providers. We expect to achieve some administrative savings as a result of the consolidation of the HHAs and hospices and the reduction in the number of intermediaries serving them. Savings will be associated with reduced systems modification expenses and with minimal economies-of-scale that would lower unit processing costs. The potential savings, coupled with the one-time costs, will not begin to approach the \$100 million threshold and would not produce a major increase in cost or prices.

Generally, we consider an adverse effect on employment, productivity, innovation, or competition to be significant only if that effect is

equivalent to an economic loss of \$10 million or more, and the adverse effect results in a 10 percent or greater change in a year for a common measurement of an economic variable of the affected entities. For the reasons discussed above, we expect these proposed reassignments to have beneficial, rather than adverse, effects on productivity and possibly on innovation. Further, although the reassignment of provider-based HHAs and hospices to fewer intermediaries might result in a reduced level of employment by those intermediaries that will no longer serve those providers, we believe this will be of insignificant magnitude.

Finally, we have determined that this rule will not have an adverse effect on competition. Section 1816 of the Act gives providers the right to nominate their servicing intermediary. Because of this, HCFA, in selecting intermediaries, is exempt by operation of law from the requirement of competition that governs most Federal procurements. Historically, with the exception of a few contracts entered into under experimental or demonstration contracting authority, intermediaries have been administratively selected without competition. This designation of regional intermediaries for provider-based HHAs and hospices is consistent with existing law and policy. For the above reasons, we have determined that the assignment and reassignment of provider-based HHAs and hospices to the designated regional intermediaries do not meet any of the criteria for identifying major rules. Therefore, a regulatory impact analysis is not required.

B. Regulatory Flexibility Act

Consistent with the Regulatory Flexibility Act (RFA) (5 U.S.C. 601-612), we prepare and publish a regulatory flexibility analysis for regulations unless the Secretary certifies that the regulations 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.

For the reasons given, we have determined, and the Secretary certifies, that these regulations will not have a significant economic impact on a substantial number of small entities. Therefore, a regulatory flexibility analysis is not required. Nevertheless, in the spirit of E.O. 12291 and the RFA, we are voluntarily providing the following information.

This rule will have an impact upon approximately 30 percent of the Medicare-certified hospices. It also requires reassignment of a substantial number of provider-based HHAs to the

designated regional intermediaries and, for purposes of regulatory flexibility analysis, we consider all providers and other entities participating in Medicare to be small entities. However, we have determined that the impact on the affected entities will be insignificant.

Since audit and fiscal functions will remain the responsibility of the affected providers' current intermediaries, the impact of assignment to the designated intermediaries will be slight. Additionally, we will provide reasonable advance notice of the change-over date and will make every effort to assure a continued cash flow for each of the affected providers. For these reasons, we believe, and the Secretary certifies, that this rule will not result in a significant impact on a substantial number of small entities. Therefore, a regulatory flexibility analysis is not required.

Paperwork Burden

Section 421.117(f) of this rule contains information collection requirements that are subject to Office of Management and Budget review under the Paperwork Reduction Act of 1980. A notice will be published in the *Federal Register* when approval is obtained.

List of Subjects in 42 CFR Part 421

Administrative practice and procedure, Health facilities, Health professions, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 421 is amended as set forth below:

PART 421—INTERMEDIARIES AND CARRIERS

1. The authority citation for Part 421 continues to read as follows:

Authority: Secs. 1102, 1815, 1816, 1833, 1842, 1861(u), 1871, 1874, and 1875 of the Social Security Act (42 U.S.C. 1302, 1395g, 1395h, 1395l, 1395u, 1395x(u), 1395hh, 1395kk, and 1395ll), and 42 U.S.C. 1395b-1.

2. Section 421.3 is revised by removing the modifier "freestanding" that applies to home health agencies to read as follows:

§ 421.3 Definitions.

"Intermediary" means an entity that has a contract with HCFA to determine and make Medicare payments for Part A or Part B benefits payable on a cost basis and to perform other related functions. For purposes of designating regional or alternative regional intermediaries for home health agencies and of designating intermediaries for hospices under § 421.117 as well as for applying the performance criteria in § 421.120 and the statistical standards in

§ 421.122 and any adverse action resulting from such application, the term intermediary also means a Blue Cross Plan which has entered into a subcontract approved by HCFA with the Blue Cross and Blue Shield Association to perform intermediary functions.

3. In § 421.100, the introductory paragraph is republished for the convenience of the reader and a new paragraph (i) is added to read as follows:

§ 421.100 Intermediary functions.

An agreement between HCFA and an intermediary shall provide for the performance of the following functions:

(i) *Dual intermediary responsibilities.* With respect to the responsibility for service to provider-based HHAs and provider-based hospices, where the HHA or hospice and its parent provider will be served by different intermediaries under § 421.117 of this part, the designated regional intermediary will process bills, make coverage determinations and make payments to the HHAs and hospices. The intermediary serving the parent provider will perform all fiscal functions, including audits and settlement of the Medicare cost reports and the HHA and hospice supplement worksheets.

4. Section 421.117 is amended by redesignating paragraphs (b) through (g) as (c) through (h) respectively, adding a new paragraph (b), and revising paragraphs (a), (c), and (d) through (h). As revised, § 421.117 reads as follows:

§ 421.117 Designation of regional and alternative designated regional intermediaries for home health agencies and hospices.

(a) This section is based on section 1816(e)(4) of the Social Security Act, which requires the Secretary to designate regional intermediaries for home health agencies (HHAs) other than hospital-based HHAs but permits him or her to designate regional intermediaries for hospital-based HHAs only if the designation meets promulgated criteria concerning administrative efficiency and effectiveness; on section 1816(e)(5) of the Social Security Act, which requires the Secretary to designate intermediaries for hospices; and on section 1874 of the Act, which permits HCFA to contract with any organization for the purpose of making payments to any provider that elects to receive payment directly from HCFA.

(b) HCFA applies the following criteria to determine whether the assignment of hospital-based HHAs to designated regional intermediaries will result in the more effective and efficient administration of the Medicare program:

- (1) Uniform interpretation of Medicare rules;
- (2) Expertise in bill processing;
- (3) Control of administrative costs;
- (4) Ease of communication of program policy and issues to affected providers;
- (5) Ease of data collection;
- (6) Ease of HCFA's monitoring of intermediary performance; and
- (7) Other criteria as the Secretary believes to be pertinent.

(c) Except as provided in paragraphs (e), (f), and (g) of this section, an HHA must receive payment through a regional intermediary designated by HCFA.

(d) Except as provided in paragraphs (f) through (h) of this section, a hospice must receive payment for covered services furnished to Medicare beneficiaries through an intermediary designated by HCFA.

(e) An HHA chain not desiring to receive payment from designated regional intermediaries may request service by one lead intermediary with the assistance of a local designated regional intermediary. Alternatively, the chain may request to be serviced by a single intermediary. A lead, local, or a single intermediary must be an organization that is a designated regional intermediary. Any request made under this paragraph is evaluated by HCFA in accordance with the criteria contained at § 421.106 of this subpart.

(f) An HHA or hospice not wishing to receive payment from a regional intermediary designated under paragraph (c) or (d) of this section may submit a request to the HCFA Regional Office to receive payment through an alternative regional intermediary designated by HCFA.

(g) Except as provided in paragraph (h) of this section, any request that an HHA or hospice may make to change from a designated regional intermediary to an alternative designated regional intermediary, in accordance with paragraph (f) of this section, is evaluated by HCFA in accordance with the criteria set forth at § 421.106(b) of this subpart and must be filed within the timeframe established at § 421.106(a) of this subpart.

(h) *Exception:* An HHA or a hospice that, as of June 20, 1988 is receiving payment from a designated regional intermediary may, without regard to the limitations contained in § 421.106 of this subpart, continue to receive payment from that intermediary. It may do so even if that intermediary is not the

designated regional intermediary or the alternative designated regional intermediary for the particular State in which the HHA or hospice is located.

5. Section 421.128(f) is revised by removing the modifier "freestanding" that applies to home health agencies and hospices to read as follows:

§ 421.128 Intermediary's opportunity for hearing and right to judicial review.

* * * * *

(f) *Exception.* An intermediary adversely affected by the designation of a regional intermediary or an alternative regional intermediary for HHAs, or an intermediary for hospices, under § 421.117 of this subpart is not entitled to a hearing or judicial review concerning adverse effects caused by the designation of an intermediary.

(Catalog of Federal Domestic Assistance Programs No. 13.773, Medicare—Hospital Insurance)

Dated: February 22, 1988.

William L. Roper,
Administrator, Health Care Financing Administration.

Approved: April 1, 1988.

Otis R. Bowen,
Secretary.

[FR Doc. 88-11206 Filed 5-18-88; 8:45 am]
BILLING CODE 4120-03-M

FEDERAL EMERGENCY MANAGEMENT AGENCY

44 CFR Part 64

[Docket No. FEMA 6788]

List of Communities Eligible for the Sale of Flood Insurance; North Carolina

AGENCY: Federal Emergency Management Agency, FEMA.

ACTION: Final rule.

SUMMARY: This rule lists communities participating in the National Flood Insurance Program (NFIP). These communities were required to adopt floodplain management measures compliant with the NFIP revised regulations that became effective on October 1, 1986. If the communities did not do so by the specified date, they would be suspended from participation in the NFIP. The communities are now in compliance. This rule withdraws the suspension. The communities' continued participation in the program authorizes the sale of flood insurance.

EFFECTIVE DATE: April 5, 1988.

ADDRESS: Flood insurance policies for property located in the communities

listed can be obtained from any licensed property insurance agent or broker serving the eligible community, or from the NFIP at: P.O. Box 457, Lanham, Maryland 20706. Phone: (800) 638-7418.

FOR FURTHER INFORMATION CONTACT:

Frank H. Thomas, Assistant Administrator, Office of Loss Reduction, Federal Insurance Administration, (202) 646-2717, Federal Center Plaza, 500 C Street, Southwest, Room 416, Washington, DC 20472.

SUPPLEMENTARY INFORMATION: The NFIP enables property owners to purchase flood insurance at rates made reasonable through a Federal subsidy. In return, communities agree to adopt and administer local floodplain management measures aimed at protecting lives and new construction from future flooding.

In addition, the Director of the Federal Emergency Management Agency has identified the Special Flood Hazard Areas in these communities by publishing a Flood Insurance Rate Map. In the communities listed where a flood map has been published, section 102 of the Flood Disaster Protection Act of 1973, as amended, requires the purchase of flood insurance as a condition of Federal or federally related financial assistance for acquisition or construction of buildings in the Special Flood Hazard Area shown on the map.

The Director finds that the delayed effective dates would be contrary to the public interest. The Director also finds that notice and public procedure under 5 U.S.C. 553(b) are impracticable and unnecessary.

The Catalog of Domestic Assistance Number for this program is 83.100 "Flood Insurance."

Pursuant to the provisions of 5 U.S.C. 605(b), the Administrator, Federal Insurance Administration, to whom authority has been delegated by the Director, Federal Emergency Management Agency, hereby certifies that this rule, if promulgated will not have a significant economic impact on a substantial number of small entities. This rule provides routine legal notice stating the community's status in the NFIP and imposes no new requirements or regulations on these participating communities.

List of Subjects in 44 CFR Part 64

Flood insurance, Floodplains.

PART 64—[AMENDED]

1. The authority citation for Part 64 continues to read as follows:

Authority: 42 U.S.C. 4001 *et seq.*,
Reorganization Plan No. 3 of 1978, E.O. 12127.

2. Section 64.6 is amended by adding in alphabetical sequence new entries to the table.

In each entry, the suspension for each listed community has been withdrawn. The entry reads as follows:

§ 64.6 List of eligible communities.

State	Community name	County	Community No.	Effective date
North Carolina	Charlotte, city of	Mecklenburg	370159	April 5, 1988, suspension withdrawn.
Do	Gastonia, city of	Gaston	370100	Do.
Do	Harrisburg, town of	Cabarrus	370038	Do.
Do	Indian Trail, town of	Union	370235	Do.
Do	Kings Mountain, city of	Cleveland	370304	Do.
Do	Long View, town of	Catawba	370055	Do.
Do	Unincorporated areas	Mecklenburg	370158	Do.
Do	Mount Holly, city of	Gaston	370102	Do.
Do	Spencer, town of	Rowan	370216	Do.
Do	Wingate, town of	Union	370365	Do.

Harold T. Duryee,
Administrator, Federal Insurance
Administration.

Issued: May 8, 1988.

[FR Doc. 88-11205 Filed 5-18-88; 8:45 am]

BILLING CODE 6718-21-M

44 CFR Part 64

[Docket No. FEMA 6789]

List of Communities Eligible for the Sale of Flood Insurance; Pennsylvania et al.

AGENCY: Federal Emergency Management Agency.

ACTION: Final rule.

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

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

ADDRESS: Flood insurance policies for property located in the communities listed can be obtained from any licensed property insurance agent or broker serving the eligible community, or from the National Flood Insurance Program

(NFIP) at: P.O. Box 457, Lanham, Maryland 20706, Phone: (800) 638-7418.

FOR FURTHER INFORMATION CONTACT: Frank H. Thomas, Assistant Administrator, Office of Loss Reduction, Federal Insurance Administration, (202) 646-2717, Federal Center Plaza, 500 C Street, Southwest, Room 416, Washington, DC 20472.

SUPPLEMENTARY INFORMATION: The National Flood Insurance Program (NFIP), enables property owners to purchase flood insurance at rates made reasonable through a Federal subsidy. In return, communities agree to adopt and administer local floodplain management measures aimed at protecting lives and new construction from future flooding. Since the communities on the attached list have recently entered the NFIP, subsidized flood insurance is now available for property in the community.

In addition, the Director of the Federal Emergency Management Agency has identified the special flood hazard areas in some of these communities by publishing a Flood Hazard Boundary Map. The date of the flood map, if one has been published, is indicated in the fourth column of the table. In the communities listed where a flood map has been published, section 102 of the Flood Disaster Protection Act of 1973, as amended, requires the purchase of flood insurance as a condition of Federal or federally related financial assistance for acquisition or construction of buildings in the special flood hazard area shown on the map.

The Director finds that the delayed effective dates would be contrary to the public interest. The Director also finds that notice and public procedure under 5 U.S.C. 553(b) are impracticable and unnecessary.

The Catalog of Domestic Assistance Number for this program is 83.100 "Flood Insurance."

Pursuant to the provisions of 5 U.S.C. 605(b), the Administrator, Federal Insurance Administration, to whom authority has been delegated by the Director, Federal Emergency Management Agency, hereby certifies that this rule, if promulgated will not have a significant economic impact on a substantial number of small entities. This rule provides routine legal notice stating the community's status in the NFIP and imposes no new requirements or regulations on participating communities.

List of Subjects in 44 CFR Part 64

Flood insurance, Floodplains.

PART 64—[AMENDED]

1. The authority citation for Part 64 continues to read as follows:

Authority: 42 U.S.C. 4001 *et seq.*,
Reorganization Plan No. 3 of 1978, E.O. 12127.

2. Section 64.6 is amended by adding in alphabetical sequence new entries to the table.

In each entry, a complete chronology of effective dates appears for each listed community. The entry reads as follows:

§ 64.6 List of eligible communities.

State and location	Community No.	Effective dates of authorization/cancellation of sale of flood insurance in community	Current effective map date
Pennsylvania: Smithfield, township of, Monroe County.	421896	Nov. 8, 1974, Emerg.; Mar. 4, 1988, Reg.; Mar. 4, 1988, Susp.; Apr. 5, 1988, Rein.	Mar. 4, 1988.
Kentucky: Greenup, city of, Greenup County	210088	Dec. 15, 1975, Emerg.; July 5, 1982, Reg.; Feb. 4, 1988, Susp.; Apr. 5, 1988, Rein.	July 5, 1982.
Woodford County, unincorporated areas.	210230	Mar. 30, 1973, Emerg.; June 1, 1978, Reg.; Feb. 4, 1988, Susp.; Apr. 6, 1988, Rein.	June 1, 1978.