reasonableness of state action The Clean Air Act forbids EPA to base its actions concerning SIPs on such grounds. *Union Electric Co v U.S. E.P.A.*, 427 U.S. 246, 256–66 (1976); 42 U.S.C. 7410(a)(2).

EPA's disapproval—of the portion of the submittal containing Missoula's variance rule—under section 110 and subchapter I, part D of the Clean Air Act does not affect any existing requirements applicable to small entities. Any pre-existing Federal requirements remain in place after this disapproval. Federal disapproval of the state submittal does not affect its state-enforceability. Moreover, EPA's disapproval of the submittal does not impose any new Federal requirements. Therefore, EPA certifies that this disapproval action does not have a significant impact on a substantial number of small entities because it does not remove existing requirements nor does it impose any new Federal requirements.

Under section 307(b)(1) of the Clean Air Act, petitions for judicial review of this action must be filed in the United States Court of Appeals for the appropriate circuit by February 13, 1995. Filing a petition for reconsideration by the Administrator of this final rule does not affect the finality of this rule for the purposes of judicial review nor does it extend the time within which a petition for judicial review must be filed, and shall not postpone the effectiveness of such rule or action. This action may not be challenged later in proceedings to enforce its requirements (see section 307(b)(2)).

The Office of Management and Budget (OMB) has exempted this regulatory action from E.O. 12866 review.

List of Subjects in 40 CFR Part 52

Environmental protection, Air pollution control, Carbon monoxide, Hydrocarbons, Incorporation by reference, Intergovernmental relations, Nitrogen dioxide, Particulate matter, Reporting and recordkeeping requirements, Sulfur dioxide, Volatile organic compounds.

Dated: November 29, 1994.

William P. Yellowtail,

Regional Administrator

Chapter I, title 40 of the Code of Federal Regulations is amended as follows:

PART 52—[AMENDED]

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

Authority: 42 U.S.C. 7401–7671q.

Subpart BB—Montana

2. Section 52.1370 is amended by adding paragraph (c)(35) to read as follows:

§ 52.1370 Identification of plan.

* * * * *

(c) * * *

(35) The Governor of Montana submitted PM_{10} and CO contingency measures for Missoula, Montana in a letter dated March 2, 1994. The Governor of Montana also submitted the Missoula City-County Air Pollution Control Program in a letter dated August 20, 1991, with amendments submitted in letters dated June 4, 1992 and March 2, 1994. The March 2, 1994 submittal satisfies several commitments made by the State in its original PM_{10} moderate nonattainment area SIP.

(i) Incorporation by reference.

(A) Board order issued on November 19, 1993 by the Montana Board of Health and Environmental Sciences approving the amendments to Missoula City-County Air Pollution Control Program Chapter VII, VIII, and IX, regarding, among other things, the PM_{10} and CO contingency measures, inspections, emergency procedures, permitting, and wood-waste burners.

(B) Missoula City-County Chapter IX, Subchapter 3, effective November 19, 1993, which addresses the PM_{10} and CO contingency measure selection process.

(C) Missoula City-County Rule 1401(7), effective November 19, 1993, which addresses PM_{10} contingency measure requirements for an expanded area of regulated road sanding materials.

(D) Missoula City-County Rule 1428(5) and 1428(7), effective November 19, 1993, which addresses PM_{10} and CO contingency measure requirements for solid fuel burning devices.

(E) Missoula City-County Air Pollution Control Program Chapter IX, Subchapter 13, Open Burning, effective June 28, 1991.

(F) Other Missoula City-County Air Pollution Control Program regulations effective June 28, 1991, with amendments effective on March 20, 1992 and November 19, 1993, as follows: all portions of Chapter IX, Subchapter 11, Permit, Construction and Operation of Air Contaminant Sources, except, Rules 1102(3), 1105(2), and 1111(2).

(G) Other Missoula City-County Air Pollution Control Program regulations effective June 28, 1991, with amendments effective on November 19, 1993, as follows: Chapter IX, Subchapter 4, Emergency Procedures and Chapter IX, Subchapter 14, Rule 1407, Prevention, Abatement and Control of Air Pollution from Wood-Waste Burners.

(H) Minor revisions to Missoula City-County Air Pollution Control Program Chapter VII, Air Quality Advisory Council, and Chapter VIII, Inspections, effective on November 19, 1993, as follows: Chapter VII(1) and Chapter VIII(4).

3. Section 52.1390 is added to read as follows:

§ 52.1390 Missoula Variance Provision.

The Missoula City-County Air Pollution Control Program's Chapter X, Variances, which was adopted by the Montana Board of Health and Environmental Sciences on June 28, 1991 and submitted by the Governor of Montana to EPA in a letter dated August 20, 1991, is disapproved. This rule is inconsistent with section 110(i) of the Clean Air Act, which prohibits any State or EPA from granting a variance from any requirement of an applicable implementation plan with respect to a stationary source.

[FR Doc. 94–30512 Filed 12–12–94; 8:45 am]

BILLING CODE 6560–50–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Public Health Service

42 CFR Part 65

RIN 0905–AD69

National Institute of Environmental Health Sciences Hazardous Waste Worker Training

AGENCY: National Institutes of Health, Public Health Service, HHS.

ACTION: Final rule.

SUMMARY: The National Institutes of Health (NIH) is amending regulations governing the National Institute of Environmental Health Sciences Hazardous Waste Worker Training Program to make them applicable to the new Hazmat Employee Training Grants Program authorized by section 118 of the Hazardous Materials Transportation Act, as amended by the Hazardous Materials Transportation Uniform Safety Act of 1990.

EFFECTIVE DATE: Effective January 12, 1995.

FOR FURTHER INFORMATION CONTACT: Chip Hughes, Worker Education and Training Program, Office of Disease Prevention, P. O. Box 12233, NIEHS, West Campus, MD WC–04, Research Triangle Park, North Carolina 27709, telephone (919) 541–0217 (this not a toll-free number).

SUPPLEMENTARY INFORMATION: The Hazardous Materials Transportation Uniform Safety Act (HMTUSA) of 1990, Public Law 101–615, enacted on November 16, 1990, amends the Hazardous Materials Transportation Act (HMTA) (49 U.S.C. Appendix 1801 *et seq.*) by authorizing the National Institute of Environmental Health Sciences (NIEHS) of the National Institutes of Health to administer a program of grants to qualified non-profit organizations for the purpose of providing training and education to hazardous materials employees regarding the safe unloading, loading, handling, storage and transportation of hazardous materials and emergency preparedness for responding to accidents or incidents involving the transportation of hazardous materials in order to meet the training requirements issued under section 106(b) of the HMTA. Section 118 of the HMTA directs NIEHS to administer the Hazmat Employee Training Grant Program in consultation with the Secretary of the U.S. Department of Transportation (DOT), the Administrator of the Environmental Protection Agency (EPA) and the Secretary of the U.S. Department of Labor (DOL). The grants are funded from the collection of fees, as specified under section 117A(h) of the HMTA, which are collected from the transporters of hazardous materials on an annual basis. Funds to support the grant program are transferred from DOT to NIEHS on an annual basis through an Interagency Agreement.

This rule amends regulations at 42 CFR part 65 governing the NIEHS Hazardous Waste Worker Training Grants Program to make them applicable to the new Hazmat Employee Training Grants Program. Specifically, the authority citation for part 65 is amended to include the authority for the new training grants (49 U.S.C. App. 1816); § 65.1 is amended by revising paragraphs (a), (b) concluding text and (c) introductory text to set forth the applicability of part 65 to the Hazmat Employee Training Grant Program; and § 65.2 is amended by deleting the definition of "Act" and adding definitions of the acronyms "SARA" and "HMTA" and by revising the definition of "Award or grant." Additionally, references to "section 126 of the Act" found in sections 65.1, 65.4 and 65.5 of the part 65 are revised to read "section 126 of the SARA or section 118 of the HMTA."

Further, Public Law 103–227, enacted on March 31, 1994, prohibits smoking in certain facilities in which minors will be present. The Department of Health and Human Services is now preparing to implement the provisions of that law. Until those implementation plans are in place, PHS continues to strongly encourage all grant recipients to provide a smoke-free workplace and promote the nonuse of all tobacco products.

On September 29, 1993, NIH published a notice of proposed rulemaking in the **Federal Register** announcing our plans to amend the regulations governing the Hazardous Waste Worker Training Program at 42 CFR part 65 by making these changes and invited public comment. We received two comments on the proposed changes. These comments were received from the George Meany Center for Labor Studies and the Chemical Waste Transportation Institute of the National Solid Wastes Management Association.

Comment: The George Meany Center for Labor Studies suggested that the inclusion of both planning grants and program grants in part 65 is inconsistent with section 118(c) of the amended HMTA which restricts funding to "non-profit organizations which previously have demonstrated their expertise in implementing and operating hazmat employee training and education programs."

Response: While planning grants are an option for NIEHS in the overall training program under the Superfund Amendments and Reauthorization Act of 1986 (SARA), it would not be an option with the HMTA Hazmat Employee Training Grant Program since the statute is so narrowly drawn. In response to the comment, we have clarified § 65.1 (c) to indicate that planning grants are available only under SARA.

Comment: The Chairman of the Chemical Waste Transportation Institute suggested the title heading of part 65 be expanded to make reference to both types of grants programs. He suggested the heading be altered to read: "NIEHS Hazardous Waste Worker Training and Hazmat Employee Training Grant Programs."

Response: NIEHS prefers to retain the original title heading of part 65 which is generically descriptive of the kinds of programs covered, including additions of new programs related to hazardous waste worker training and additions to a program's purview and statutory authority. The public will be notified of the availability of funds for particular programs through the standard process of the issuance by NIH of Requests for Applications (RFA). Hence, there is no need for changing the program's general title with every new statutory or regulatory amendment.

Accordingly, no changes have been made in the proposed rule, except for minor editorial changes.

Regulatory Impact Statement

. Executive Order No. 12866 of September 30, 1993, Regulatory Planning and Review, requires us to prepare an analysis for any rule that meets one of the E. O 12866 criteria for a significant regulatory action, that is, that may—

Have an annual effect on the economy of $100 million or more or adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, or tribal, governments, or communities,

Create a serious inconsistency or otherwise interfere with an action taken or planned by another agency;

Materially alter the budgetary impact of entitlements, grants, user fees, or loan programs or the rights and obligations of recipients thereof; or

Raise novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in E.O. 12866.

In addition, we prepare a regulatory flexibility analysis, in accordance with the Regulatory Flexibility Act of 1980 (5 U.S.C. chapter 6), if the rule is expected to have a significant impact on a substantial number of small entities.

Because this rule merely makes minor changes in the authority citation, applicability section, and definitions section to incorporate the new Hazmat Employee Training Grant Program authority into part 65, it will have no major consequential effects on the economy or small entities. Therefore, the Secretary has determined that this rule is not significant within the definition of E.O. 12866, and the Secretary certifies that this rule will not have a significant impact on a substantial number of small entities

Paperwork Reduction Act

Sections 65.4(a), (b) and (c) of part 65 contain information collection requirements subject to Office of Management and Budget (OMB) review under the Paperwork Reduction Act of 1980 (44 U.S.C. chapter 35). The information collection language in these sections is currently approved under OMB control number 0925–0348. Response burden in conjunction with the program is approved under OMB control number 0925–0001 This rule does not result in any changes in the language currently approved under control number 0925–0348

Catalog of Federal Domestic Assistance

The OMB Catalog of Federal Domestic Assistance (CFDA) numbered program affected by the subject rule is: 93.142

List of Subjects in 42 CFR Part 65

Education study programs, Grant programs—education, Grant programs—health, Hazardous materials transportation, training programs.

Dated: November 1, 1994.

Philip R. Lee,

Assistant Secretary for Health.

Approved: December 7, 1994.

Donna E. Shalala,

Secretary

For reasons set out in the preamble, part 65 of title 42 of the code of Federal Regulations is amended to read as set forth below

PART 65—NATIONAL INSTITUTE OF ENVIRONMENTAL HEALTH SCIENCES HAZARDOUS WASTE WORKER TRAINING

1 The authority citation for part 65 is revised to read as follows:

Authority: 42 U.S.C. 9660a; 49 U.S.C. App. 1816.

2. Section 65.1 is amended by revising paragraphs (a), (b) concluding text and (c) introductory text to read as follows:

§ 65.1 To what projects do these regulations apply?

(a) The regulations in this part apply to:

(1) The program of grants for the training and education of workers who are or are likely to be engaged in activities related to hazardous waste removal or containment, or emergency response that is authorized under section 126(g) of the SARA, and

(2) The program of grants to support qualified non-profit organizations for the purpose of providing training and education to hazardous materials employees regarding: the safe unloading, loading, handling, storage, and transportation of hazardous materials; and, emergency preparedness for responding to accidents or incidents involving the transportation of hazardous materials that is authorized under section 118 of the HMTA.

(b) * * *

(1) * * *

* * * * *

Target populations may also be regulated under standards promulgated by the Secretary of Labor, the Secretary of Transportation, the Administrator of the Environmental Protection Agency, and other agencies under section 126(g) of the SARA or section 106(b) of the HMTA.

(c) Two types of grants are available: Program grants covering the full range of activities, including program development, direct worker training and education, and program evaluation; and planning grants under the SARA.

* * * * *

3. Section 65.2 is amended by removing the definition of "Act" and by adding in alphabetical order definitions of the acronyms "HMTA" and "SARA", and by revising the definition of "Award or grant", to read as follows:

§ 65.2 Definitions.

As used in this part:

Award or *grant* means a grant or cooperative agreement made under section 126(g) of the SARA or section 118 of the HMTA.

* * * * *

HMTA means the Hazardous Materials Transportation Act, as amended (49 U.S.C. App. 1801 *et seq.*).

* * * * *

SARA means the Superfund Amendments and Reauthorization Act of 1986, Public Law 99–499, as amended (42 U.S.C. 9601 *et seq.*).

* * * * *

4. Section 65.4 is amended by revising paragraph (b) to read as follows:

§ 65.4 Project requirements.

* * * * *

(a) * * *

(b) Each applicant must detail the nature, duration, and purpose of the training for which the application is filed. The proposed training program must meet the standards promulgated by the Secretary of Labor and Secretary of Transportation under section 126(g) of the SARA or section 106(b) of the HMTA, and such additional requirements as the Director may prescribe to ensure appropriate health and safety training.

(c) * * *

5. Section 65.5 is amended by revising paragraph (b) to read as follows:

§ 65.5 How will applications be evaluated?

(a) * * *

(b) Within the limits of funds available, the Director may award training grants to carry out those projects which have satisfied the requirements of the regulations of this part; are determined by the Director to be technically meritorious; and in the judgment of the Director best promote the purposes of the grant programs authorized by section 126(g) of the SARA or section 118 of the HMTA, the regulations of this part, and program priorities.

* * * * *

[FR Doc. 94–30557 Filed 12–12–94; 8:45 am]

BILLING CODE 4140–01–P

Health Care Financing Administration

42 CFR Parts 405 and 482

[BPD–421–F]

RIN 0938–AD11

Medicare and Medicaid Programs; Revisions to Conditions of Participation for Hospitals

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

ACTION: Final rule.

SUMMARY: This final rule establishes as a condition of participation (which facilities must meet in order to participate in the Medicare and Medicaid programs) the requirement that hospitals have a discharge planning process for patients who require such services and specifies the elements of that process. It also changes the required qualifications of a hospital's medical director These provisions implement sections 9305(c) of the Omnibus Budget Reconciliation Act of 1986 (OBRA '86) and 6025 of the Omnibus Budget Reconciliation Act of 1989

Also, we are not adopting several minor proposed revisions to the conditions for coverage of suppliers of end-stage renal disease (ESRD) services. We are now developing comprehensive revisions to the ESRD regulations and believe that it would be appropriate to reconsider the proposed changes as part of that rulemaking process.

DATES: *Effective date:* These rules are effective January 12, 1995.

FOR FURTHER INFORMATION CONTACT:

Arlene Ford (410) 966–4617—For hospital discharge planning

Beverly Christian (410) 966–4616—For qualifications of medical directors

Jackie Sheridan (410) 966–4635—For ESRD-related issues

SUPPLEMENTARY INFORMATION:

I. Background

A. General

On June 16, 1988, we published a proposed rule (53 FR 22506) concerning discharge planning as a hospital condition of participation, certain laboratory director qualifications required by recent legislation, and proposed revisions to regulations aimed at reducing paperwork and information collection requirements. In the proposal,

we explained that conditions of participation (conditions) are the requirements that hospitals must meet in order to participate in the Medicare program; hospitals that participate in the Medicaid program must meet the same requirements. These conditions implement sections 1861(e), (f), (k), and (z) of the Social Security Act (the Act).

These conditions are intended to protect patient health and safety and to help assure that high-quality care is provided to all patients. The current regulations containing the conditions of participation for hospitals are located in the Code of Federal Regulations at 42 CFR Part 482, Subparts A, B, C, D, and E. Providers are surveyed by a State survey agency to ensure that they meet our participation requirements. (Our regulations concerning survey and certification procedures for providers affected by this rule are at 42 CFR Part 488 unless otherwise noted.) Hospitals accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the American Osteopathic Association (AOA) are deemed under section 1865 of the Act and § 488.5 of our regulations to meet most of our requirements in the hospital conditions of participation and need not be routinely surveyed.

Failure to meet a condition of participation may jeopardize the continuation of a facility's participation in the Medicare or Medicaid program.

B. Discharge Planning Process

Over the past 20 years, the average length of a hospital stay has become significantly shorter for a number of reasons. Factors contributing to this reduction include payment methods for hospitals, such as Medicare's prospective payment system, which furnishes incentives to hospitals to retain only those patients needing care that can be safely furnished only in the inpatient hospital setting. Additionally, increases in the aged population, coupled with shorter lengths of hospital stays, have created a demand for rehabilitative and restorative treatments in non-hospital settings that can be furnished after hospital discharge. To assure the coordination needed to achieve a timely transition to post-hospital care, discharge planning is necessary. It enables a hospital and patient to arrange for services that do not need to be furnished in an inpatient hospital setting.

Our current regulations do not require discharge planning as a distinct condition of participation. However, we include as a standard under the quality assurance condition (42 CFR 482.21(b)) the requirement that a hospital have an effective, ongoing discharge planning program that facilitates the provision of followup care.

We require the hospital to initiate the discharge planning process in a timely manner and to transfer or refer patients, along with necessary medical information, to appropriate facilities, agencies or outpatient services, as needed, for followup or ancillary services.

C. Clinical Laboratory Director Standards

In order to assure the health and safety of patients, our conditions of participation for hospitals and conditions for coverage of services of laboratories include standards that personnel, including laboratory directors, must meet. The clinical laboratory director requirements apply in all States, including those that have adopted their own qualification requirements. When OBRA '86 was enacted, it specified in section 9339(d) that if a State has standards that a clinical laboratory director (including a hospital laboratory director) must meet, directors who meet these standards will be considered as meeting Federal standards. We included this provision in our June 16, 1988 proposed rule. Subsequently, on October 31, 1988, the enactment of the Clinical Laboratory Improvement Amendments of 1988 (CLIA), Public Law 100–578, drastically revised laboratory requirements, obviating the proposal. Because the Medicare provision has been superseded, we are withdrawing our proposal and not discussing public comments in this final rule. (See our February 28, 1992 final rule (57 FR 7002) for the regulations implementing clinical laboratory director requirements under CLIA.)

D. Other Revisions

Following the summary of changes made to the proposed rule based on our evaluation of public comments, we discuss in section VI of this preamble technical changes to our regulations concerning hospital medical director qualifications. An unrelated change inserts in regulations the new name adopted by the accrediting program of the Committee on Allied Health Education and Accreditation. These changes were not issued in a proposed rule. The first change is technical and conforms the rules to the statute without interpretation, while the second change merely updates the rules by substituting the new name of an accrediting program.

II. Legislation

Section 9305 (c)(1) and (c)(2) of OBRA '86 amends section 1861(e) of the Act, which defines "hospital", by adding to paragraph (6) a requirement that a hospital have in place a discharge planning process that meets the requirements of a new section 1861(ee) of the Act. Under section 1861(ee), a discharge planning process of a hospital is sufficient if it applies to services furnished by the hospital to Medicare beneficiaries and meets the guidelines and standards established by the Secretary of HHS to ensure a timely and smooth transition to the most appropriate type of setting for post-hospital or rehabilitative care.

Section 1861(ee) requires that the Secretary's standards and guidelines include the following:

(1) The hospital must identify, at an early stage of hospitalization, those patients who are likely to suffer adverse health consequences if discharged without adequate discharge planning.

(2) Hospitals must provide a discharge planning evaluation for the patients identified under (1) above and for other patients upon request of the patient or his or her representative or physician.

(3) Any discharge planning evaluation must be made on a timely basis to ensure that appropriate arrangements for post-hospital care will be made before discharge and to avoid unnecessary delays in discharge.

(4) A discharge planning evaluation must include an evaluation of a patient's likely need for appropriate post-hospital services and the availability of those services.

(5) The discharge planning evaluation must be included in the patient's medical record for use in establishing an appropriate discharge plan, and the results of the evaluation must be discussed with the patient or his or her representative.

(6) Upon the request of a patient's physician, the hospital must arrange for the development and initial implementation of a discharge plan for the patient.

(7) Any discharge planning evaluation or discharge plan required under section 1861(ee) of the Act must be developed by, or under the supervision of, a registered professional nurse, social worker, or other appropriately qualified personnel. (Although the statute refers to a "registered professional nurse," both in this provision and in section 1861(e)(5) of the Act, there is no distinction between this term and "registered nurse," which is more commonly used. We will hereafter use the term "registered nurse", to be

consistent with other references in our regulations.)

Section 9305(c)(3) of OBRA '86 amends section 1865(a) of the Act so that, in effect, when the JCAHO or AOA requires hospitals to have a discharge planning process or imposes a requirement that serves substantially the same purpose as the condition of participation for discharge planning, the Secretary is authorized to find that those hospitals with JCAHO or AOA accreditation meet that condition of participation.

The provisions of section 9305(c) of OBRA '86 were effective October 21, 1987

III. Provisions of the Proposed Regulations

On June 16, 1988, we published a proposed rule to implement these legislative changes as well as the clinical laboratory director standards revisions mentioned earlier (53 FR 22506). We also proposed several minor revisions to the conditions for coverage of suppliers of ESRD services to accommodate a request from the Office of Management and Budget concerning paperwork burden and reporting requirements.

A. Discharge Planning Process

To implement section 9305(c) of OBRA '86, we proposed to incorporate the provisions of the statute and would add a new hospital condition of participation, § 482.43, Discharge planning, which would have applied only to Medicare patients. We proposed to delete the current discharge planning requirement in § 482.21, Quality assurance, as a medically-related patient care service standard applicable to all patients.

Section 1861(ee) of the Act confers authority to include standards and guidelines beyond those explicitly enumerated in the statute. We proposed to specify that the discharge planning evaluation include an evaluation of the Medicare patient's capacity for self-care or the possibility of this patient being cared for in the environment from which he entered the hospital. Under the requirements for the discharge plan, we would require, on an as-needed basis, that the Medicare patient and family members or interested persons be counseled to prepare them for post-hospital care. For clarity, we wanted to include the concept in the current regulation explicitly requiring the actual transfer or referral of Medicare patients after discharge planning is complete. We also proposed to require periodic reassessment of the Medicare patient's discharge plan to determine whether it needs to be changed. We would also require the hospital to reassess its discharge planning process on an ongoing basis to ensure that it meets Medicare patients' discharge needs.

We deferred proposing any requirements relating to the needs assessment instrument that is being developed by the Secretary as required by section 9305(h) of OBRA '86. On June 30, 1992, HHS submitted a report on the needs assessment instrument to Congress including recommendations for further testing and development of the instrument.

The statutory requirement, under section 1861(ee) of the Act, mandating the inclusion of discharge planning into the hospital conditions of participation, explicitly applies only to Medicare beneficiaries. Although we believed the Secretary had the authority to expand the application of the provision beyond the statutorily mandated population, we did not choose to do so at the time we published the proposed rule, in part because we believed that additional development of mechanisms for effectively completing and executing discharge plans was warranted before a requirement as detailed as this one was made applicable beyond the mandated population. We have since changed our view and now are applying the requirement to all patients who need it. (See section IV , "Comments and Responses", below for further discussion of this issue.)

At the time of the proposal, we had not yet made a determination as authorized under section 9305(c)(3) as to whether the JCAHO or AOA discharge planning standards were at least equivalent to the statutory standards and guidelines in section 1861(ee) of the Act. Our current regulations at 42 CFR 488.5, as redesignated from 42 CFR 405.1901(d)(3) on June 17, 1988 (53 FR 22850), already provide that JCAHO and AOA accredited hospitals are deemed to meet our conditions of participation unless our requirements are higher or more precise. We indicated that we would review each organization's standards to determine if they are at least equivalent and invited comments on this issue. We requested comments from the public on this issue and proposed to announce in the final rule whether hospital compliance with the JCAHO or AOA accreditation programs would provide the Secretary with a "reasonable assurance" that the hospital met the new condition of participation.

The new section 1861(ee)(2)(B) includes the requirement that hospitals provide discharge planning evaluations upon the request of the "patient, patient's representative, or patient's physician." We proposed to characterize "patient's representative" in § 482.43(b)(1) as any properly authorized "person acting on the patient's behalf."

We proposed not to require hospitals to inform Medicare patients of the availability of discharge planning services separately from other information furnished. Currently, hospitals give all Medicare patients a notice ("An Important Message from Medicare") that informs beneficiaries, among other things, of the availability of discharge planning. This message was designed to help Medicare patients who may believe they need post-hospital services but do not know how to obtain them.

We proposed to allow hospitals to determine the appropriate personnel to carry out the discharge planning. In proposed §§ 482.43(b)(2) and 482.43(c)(1), we stated that a registered nurse, social worker, or other appropriate personnel (consistent with available community and hospital resources) must develop or supervise the development of the evaluation and discharge plan. We did not stipulate in the regulation what qualifications would need to be related to the size and location of the hospital and the variety of resources available for post-discharge care in the area. In our interpretive guidelines, though, we would instruct the surveyor to look at such factors as previous experience in discharge planning, knowledge of clinical and social factors that affect functional status at discharge, knowledge of community resources to meet post-discharge clinical and social needs, and assessment skills.

To be compatible with our other regulations we proposed to divide this condition of participation into several standards: the first, identification of Medicare patients in need of evaluation; the second, the evaluation process; the third, the discharge plan, and the fourth, referral or transfer of the Medicare patient, along with necessary medical information. (The statute does not explicitly require actual transfer or referral of patients after discharge planning is complete, so we proposed to retain, for clarity, the concept of current § 482.21(b)(2).) A fifth standard would require an ongoing reassessment of the discharge planning process to ensure that discharge plans are responsive to discharge needs of individual Medicare patients. Because the requirements in § 482.43 (a), (b)(1), (b)(2), (b)(3), (b)(5), (b)(6), and (c)(2) would be those required by section 1861(ee) of the Act, failure to meet any of these

requirements could result in termination of the hospital's participation agreement in the Medicare and Medicaid programs.

B. ESRD Conditions for Coverage

We also proposed several minor revisions to §§ 405.2135 and 405.2137 of the ESRD conditions for coverage. The purpose of the changes was to reduce the paperwork burden on ESRD facilities, in keeping with a request from the office of Management and Budget that we conduct an overall review of the paperwork burden and reporting requirements associated with HCFA regulations. We received no comments on the proposed changes.

At this time, however, we are working with representatives of the ESRD industry and consumers to develop comprehensive revisions to the ESRD conditions for coverage. We believe that it would be confusing and inappropriate to adopt the minor changes from the June 16, 1988 proposed rule at a time when the ESRD community is anticipating extensive revisions to the conditions for coverage. Instead, we believe it would be more appropriate to reconsider the proposed changes as part of our overall revision of the ESRD conditions. Thus, we are not adopting the proposed changes to §§ 405.2135 and 405.2137.

IV. Comments and Responses

We received comments from 21 commenters on the proposed discharge planning provision, including a number of favorable comments. The commenters consisted of hospitals, advocacy groups, local and State government agencies, individuals, provider and supplier associations, and a medical equipment supplier.

Application

Comment: One commenter disagreed with our limiting the new condition of participation to Medicare patients only. He believed we should extend coverage to all patients.

Response: We agree. We believe it is a good management practice for hospitals to assure continuity of care for all patients, and we recognize that most hospitals achieve this result through discharge planning. In this regard, we note that the JCAHO, which accredits approximately 6000 hospitals, has a discharge planning requirement that applies to all patients and that is, in our view, even more comprehensive than the one required under the law and these regulations. The practical effect of the JCAHO requirement is that discharge planning does apply to all patients in the vast majority of the nation's hospitals.

Based on our further review of the issue raised by this commenter, we now believe that the requirements in this regulation, which will be applied in the approximately 1500 hospitals not accredited by the JCAHO, should be applied to all patients who need them. Accordingly, under the authority contained in section 1861(e)(9) and 1861(ee)(1), we are expanding the applicability of the discharge planning requirements to all hospital patients who require it.

There are several reasons why we believe it is appropriate to expand the discharge planning requirement to all patients. First, expanding the requirement to all patients is consistent with the requirements set forth in current § 482.21, which has been in place since June 17, 1986 (51 FR 22042). Section 482.21(b) includes a discharge planning requirement that applies to all patients, Moreover, the commenter's suggestion also is consistent with our long-standing position that the Secretary's responsibility under section 1861(e)(9) of the Act to promulgate health and safety requirements for hospitals applies to all patients. Rather than limiting the Secretary's responsibilities to Medicare beneficiaries, section 1861(e)(9) refers to the "health and safety of individuals who are furnished services in the institution." Thus, the statute supports our decision to require that the new discharge planning procedures be applicable, as the old procedures were, to all of a hospital's patients. Clearly, adequate discharge planning is essential to the health and safety of all patients. It is not just the Medicare patient that may suffer adverse health consequences upon discharge without the benefit of appropriate planning. Such planning is vital to mapping a course of treatment aimed at minimizing the likelihood of having any patient rehospitalized for the reasons that prompted the initial hospital stay. To this extent, all of the elements of the discharge planning process that Congress has made explicitly applicable to Medicare beneficiaries are of equal value to all hospital patients in the interests of their health and safety.

As discussed above, expanding the scope of the discharge planning provisions would parallel current JCAHO and AOA requirements, which also apply to all patients. We do not believe that it is administratively feasible to separate Medicare and other patients for discharge planning purposes. Furthermore, such a separation of Medicare and other patients for discharge planning purposes might have the adverse affect of fostering a dual level of care system for Medicare and other patients. The discriminatory aspects of such a situation would be neither desirable nor supportable.

Finally, we do not believe that the cost of expanding the application of the requirement is significant. There will be no expense in the approximately 6000 hospitals accredited by the JCAHO. Moreover, in the approximately 1500 hospitals directly subject to the requirement, the marginal impact on hospital staffing is likely to be relatively small. Since our current hospital conditions of participation already require discharge planning, hospital staff must already be employed to carry out this function. We believe that the new discharge planning provisions impose only a minimal additional workload on these staff, and applying these requirements to all patients, rather than just to Medicare beneficiaries, will not have a significant incremental impact.

Comment: Two commenters explicitly suggested and many others implicitly suggested that we require written policies and procedures for the discharge planning process.

Response: We agree and are revising proposed § 482.43 to require the hospital to commit its discharge planning policies and procedures to writing. This requirement will help assure that the process is well thought out, clear, comprehensive and understood by all staff. It will also assist in monitoring the process. We believe most hospitals already have written discharge planning policies and procedures and will have little or no difficulty in complying with this requirement.

Effect of JCAHO or AOA Accreditation

Comment: We received five comments on the equivalency of the JCAHO's standards to ours. Two commenters believe the JCAHO's standards for discharge planning (and supporting standards for social work services and nursing services) to be equivalent to ours, while two believe them not to be equivalent.

Response: We have reviewed JCAHO's 1994 standards and find them to be at least equivalent to those in this final regulation. Included in our determination finding them equivalent was a consideration of the JCAHO's standards for patient assessment and education of patients and family.

We are announcing that JCAHO-accredited hospitals that participate in Medicare have been found by the

Secretary and HCFA to meet the new discharge planning requirement in 42 CFR 482.43. Those hospitals will not have to be surveyed for compliance with this requirement when the final regulation becomes effective. For these reasons, we believe no revision of the regulations at 42 CFR 488.5(a) is necessary.

Comment: The fifth commenter was philosophically opposed to accepting the equivalency of the JCAHO's discharge planning standards to ours because he believed a private agency is not accountable to the government for enforcement of its standards.

Response: We cannot accept the commenter's contention that a private agency should not be used to enforce government standards, as the statute explicitly authorizes this type of use of a private agency (section 1865(a) of the Act). In order to ensure that the hospitals the JCAHO accredits are meeting standards equivalent to HCFA's, we conduct validation surveys under section 1864(c) of the Act. Hospitals found out of compliance with conditions of participation may have their provider agreements terminated if they do not correct their deficiencies.

Comment: We received one comment concerning the equivalency of AOA standards to ours. The commenter believed that the AOA's discharge planning standards are more general than HCFA's but that they would be strengthened to meet new Medicare standards.

Response: We agree that AOA standards on discharge planning in effect at the time the commenters commented were not equal to or higher than ours. We are pleased to report that the AOA subsequently revised its standards for discharge planning.

We are announcing that AOA-accredited hospitals that participate in Medicare have been found by the Secretary and HCFA to meet the new discharge planning requirement in 42 CFR 482.43. These hospitals will not have to be surveyed for compliance with this requirement when the final regulation becomes effective. For these reasons, we believe no revision of the regulations at 42 CFR 488.5(a) is necessary.

Identification of Patients

Comment: Two commenters believed we should require hospitals to identify all Medicare patients, particularly high risk patients, in need of post-hospital care, within 24 hours of being admitted, including, for one commenter, patients appearing in the emergency room, whether or not they are admitted.

Response: We do not agree that a 24-hour limitation should be imposed on the identification requirement. Both the statute and the regulation require identification to take place "at an early stage of hospitalization." We think this is sufficient because the specific timing of identification within that context, we believe, is best left to the hospital, its staff, and the attending physician. Discharge planning presupposes hospital admission and section 9305(c) of OBRA '86 specifically indicates that discharge planning follows hospitalization. The requirements of § 482.43 do not apply to patients who appear in a hospital emergency room but are not admitted as hospital inpatients.

Comment: Three commenters thought we should require each hospital to have a policy for developing and utilizing screening criteria for identifying those patients whose medical conditions and social circumstances would warrant discharge planning and to require that the hospital review its criteria annually. As an alternative, they suggested that hospitals be required to have a procedure for identifying at an early stage patients likely to need post-acute care services.

Response: We believe the use of an outcome oriented standard is sufficient for the regulation and in accord with the basic approach used in the June 17, 1986 revision to the conditions of participation for hospitals (51 FR 22042). Hospitals will be able to choose from many methods to demonstrate compliance with the standard, and we wish to preserve their flexibility in this regard, including the option of reviewing all Medicare patients admitted to the facility. An on-going reassessment of the hospital's discharge planning process, which would include any screening or identification methods, is required in § 482.43(e).

Comment: One commenter wanted us to establish specified criteria (e.g., age, functional ability, psychosocial factors and health status), to identify patients who are likely to suffer adverse health consequences without discharge planning.

Response: As mentioned in response to the previous comment, we want to continue the approach used in the June 17, 1986 revision to the conditions of participation for hospitals, which avoided prescriptive administrative requirements through the use of language that is stated in terms of expected outcomes, thereby providing hospitals with greater flexibility. Since the criteria suggested by the commenter are overly prescriptive and not outcome oriented, we are not adopting them.

Comment: One commenter suggested that we have as an alternative to the phrase "patients who are likely to suffer adverse health consequences," "patients who are likely to be inhibited in performing activities of daily living."

Response: We do not believe it is necessary to add this category of patients because it is subsumed in the original category: someone unable to perform activities of daily living would be likely to suffer adverse health consequences.

Comment: Two commenters thought that, if there is no evaluation, hospitals should have to document in the patient's medical record that a patient is not at risk.

Response: We do not believe it is necessary to specify in regulations how a hospital may show compliance with this provision. Instead, the hospital should have the flexibility to comply with the requirement in the best way for the hospital.

Evaluation of Patients

Comment: One commenter believed there should be a mandatory written form for the evaluation, preferably in the form of a check-off list. The commenter also thought this evaluation form should include specified factors, such as social needs and capacity for self-care.

Response: At the present time, a nationally used and accepted form for all hospitals does not exist. Section 9305(h) of OBRA '86 requires the Secretary to develop uniform needs assessment instrument(s) in consultation with a panel of experts and to submit a report to Congress, which makes recommendations for the appropriate use of this instrument. The panel completed its work and forwarded its recommendations to Congress in a report on June 30, 1992. It is premature, however, to include a requirement for widespread use of the instrument in patient assessments until the instrument is fully developed, field tested, and its utility proven.

Comment: One commenter wanted us to clarify whether the patient could request the development and initiation of a discharge planning evaluation.

Response: As stated in § 482.43(b)(1), a physician or a patient (or patient's representative) may request a discharge planning evaluation.

Comment: One commenter thought the patient's physician should explicitly be included in the definition of patient representative.

Response: The statute uses the term "patient representative" in addition to references to the patient's physician, and thus we conclude that the term was

not meant to include physicians. A physician's role is defined by other Federal requirements such as those found in § 482.12(c), the condition of participation on the governing body concerning care of patients. Not including the patient's physician as his representative was not intended to limit or eliminate the role of the physician in decisions about a patient's medical care, including the setting in which the care is provided, nor was it meant to imply that the physician does not serve the patient's interest.

Comment: We received one favorable comment concerning the inclusion of registered nurses and social workers as qualified personnel who develop or supervise the development of the evaluation and discharge plan. We also received two comments indicating that registered nurses and social workers should have additional training or credentialing.

Response: The statute provides that the Secretary may view the existing training and credentialing a registered nurse or social worker receives as sufficient for discharge planning and we see no need to impose further requirements.

Comment: Four commenters remarked about the provision to allow "other appropriately qualified personnel" to develop or supervise the development of the evaluation and discharge plan. One commenter thought we should omit "other appropriately qualified personnel"; three thought we should specify in regulations rather than interpretive guidelines the qualifications these personnel should have.

Response: It is our policy to avoid specifying credentials in the conditions of participation wherever possible. Such requirements could inappropriately restrict hospital selection of staff, may superimpose the requirements of private groups over State law, and do not necessarily ensure the provision of quality care. We believe that including the criteria in the interpretive guidelines will assure that minimum standards are met while allowing State surveyors to monitor the requirement. In the future we will reevaluate the effectiveness of the interpretive guidelines based on survey experience.

Comment: Two commenters believed we should delete the phrase "(consistent with available community and hospital resources)" that we had included for hospitals that might have difficulty obtaining and retaining qualified personnel. The commenters believed this provision dilutes the statute. Another commenter suggested that as an alternative we add that a hospital may arrange a contractual agreement to meet the discharge plan requirement.

Response: We are deleting the parenthetical phrase both in § 482.43 (b)(2) and (c)(1) after reevaluating its appropriateness. We agree with the commenters that, in the present circumstances, the parenthetical phrase inadvertently dilutes the statute. We are not accepting the second comment as to do so would be superfluous; the condition of participation for the hospital's governing body already contains a standard at § 482.12(e) for all contracted services. The hospital's governing body must ensure that a contractor for services (including one for shared services and joint ventures) furnishes services that permit the hospital to comply with all applicable conditions of participation and standards for the contracted services.

Comment: One commenter thought we should add a requirement that "other appropriately qualified personnel" should be supervised by a registered nurse or social worker.

Response: To accept this comment would conflict with the statute, which places "other appropriate qualified personnel" as equals in qualifications of registered nurses and social workers. Indeed, these personnel may be more suited for discharge planning by virtue of credentials or training and in some cases, such as in a rural hospital, it may be a physician who does the discharge planning. We would like to note that in any event it is a management function of the hospital to assure proper supervision of its employees and we do not wish to interfere with this function.

Comment: One commenter thought HCFA should devise a certification program with time-limited certificates.

Response: We do not believe such a certification program is warranted or intended by the legislation. It is not our view that this regulation should enfranchise people with certain credentials at the expense of others who have the requisite abilities to do the job, regardless of how the abilities were acquired.

Comment: One commenter believed the regulation should explicitly reaffirm existing Medicare legal requirements that all Medicare beneficiaries have the freedom to choose the vendor for post-hospital care.

Response: Section 1802 of the Social Security Act guarantees free choice by Medicare patients. It provides that any individual entitled to Medicare may obtain health services from any institution, agency, or person qualified to participate under the Medicare law if the institution, agency, or person undertakes to provide him or her those services. We do not believe it is necessary to reaffirm this requirement in the standard for discharge planning evaluation. There is nothing in this rule that prevents a Medicare beneficiary from exercising freedom of choice of a post-hospital vendor of services.

Comment: One commenter thought that we should specify that the evaluation include an assessment of biopsychosocial needs, the patient's and family's understanding of discharge needs, and the identification of health and social care resources needed to assure high-quality post-hospital care.

Response: We do not believe that this specificity is needed in the regulation. Our approach is consistent with that used in the June 17, 1986 regulatory revision to the conditions of participation for hospitals, which avoided prescriptive administrative requirements and use of specific details. Although the factors mentioned by the commenter are relevant, it is not our intention to create an "all-inclusive" list in the regulation. We will consider these, as well as other factors, when formulating interpretive guidelines.

Comment: One commenter believed that it would be more meaningful if the regulation required the discharge evaluation to specify the type of post-hospital services that a given patient would require and the availability of those services from vendors in the community.

Response: We believe the current language of the final regulation, which is stated in terms of expected outcomes, provides hospitals with sufficient flexibility and is in accord with the philosophy of the June 17, 1986 revision to the conditions of participation for hospitals. We do not agree that the degree of specificity desired by the commenter is needed in the regulation. His comments will, however, be considered for inclusion in the interpretive guidelines.

Comment: Three commenters addressed the inclusion of § 482.43(b)(4), which requires an evaluation of the patient's capacity for self-care or of the possibility of the patient being cared for in the environment from which he or she entered the hospital. Two commenters believed paragraph (b)(4) to be a positive addition and supported inclusion of this element in the evaluation. The third commenter stated that § 482.43 (b)(3) and (b)(4) are duplicative.

Response: We disagree with the third commenter. The intent of the two paragraphs is as follows: § 483.43(b)(3) reproduces the statutory provision,

while (b)(4) specifies an element that must be included in the evaluation that is not necessarily apparent from the text of the statute.

Comment: One commenter believed that we should require that more than a patient's capacity for self-care be considered. The commenter urged that we consider the patient's wishes as well, as some persons with limited capacity for self-care may be cared for at home. Also, the commenter indicated that emphasis on capacity for self-care can lead to an overemphasis on care in a skilled nursing facility (SNF) rather than by a home health agency (HHA).

Response: The patient's wishes are an integral aspect of the capacity for self-care, since the capacity includes not only the patient's ability for self-care, but also the willingness for such care. There are a variety of services that are provided equally well by both SNFs and HHAs. A determination of which provider is appropriate depends necessarily on other conditions such as ability, availability, and willingness of caregivers, the availability of resources in the community, and patient preference. All these factors need to be considered.

Comment: One commenter believed we should emphasize that the hospital should give each beneficiary the full range of options to consider for post-hospital care rather than focusing on returning him or her to his or her prehospitalization environment, particularly when the prehospitalization environment is an SNF.

Response: In most instances the focus on a return to the prehospitalization environment is a valid one, serving the interests of the patient within available community resources. Alternatively, the regulations call for an assessment of the patient's ability for self-care. We do not believe these alternative elements of the evaluation preclude a patient from being offered a full range of options to consider for post-hospital care and we see no need to change the regulation.

To allay the commenter's concern, however, we will include a statement in the interpretive guidelines to assure that patients admitted to a hospital from an SNF are not shortchanged by the hospital discharge planning process. We would like to point out that sometimes a patient's expectations of where he or she wants to go after hospital discharge (e.g., a return to the patient's former residence rather than to the SNF from which he or she was admitted) are not realistic due to the patient's physical or mental condition, available community resources, or any one or more of these three.

Comment: Two commenters thought we should delete the phrase, "to the greatest extent possible," from the requirements for making appropriate arrangements for post-hospital care before discharge, as this is contrary to the statute and waters it down.

Response: We are removing the phrase as requested. It was not our intent to weaken this statutory provision.

Comment: One commenter believed that the patient should be consulted in the process of the evaluation and not simply after the fact. Three commenters believed we should require the involvement of the patient and family in the discharge plan. One commenter believed we should require a meeting with the patient or patient representative for input and plan approval.

Response: While we do not believe it is appropriate to mandate involvement of the patient and family in every case, the regulations do not preclude such involvement. We would hope that hospital staff would be open to information that the patient or his family might like to provide to make the discharge as easy and effective as possible.

Discharge Plan

Comment: Two commenters believe that the statute requires a hospital to develop a discharge plan only upon request of a physician.

Response: The purpose of the legislation is to assure that patients receive any necessary discharge planning, not to ensure that a hospital develops a discharge plan only upon a physician's request. We agree that the physician is important to the discharge plan, and we included a provision to require a hospital to develop a discharge plan if a physician requests one, even if the hospital had determined one to be unnecessary. This provision, based on the statute, gives the physician the final decision as to whether a discharge plan is necessary but does not unnecessarily require his input on a routine basis.

Comment: Four commenters remarked about the use of the word "assist" in § 482.43(c)(3), which requires the hospital to "assist in implementing the * * * discharge plan." One commenter liked the word "assist" as it requires the hospital to become involved without placing the entire responsibility on the hospital. Two commenters objected to the word as it is vague and passive; the statute requires the hospital to be the initiator of discharge planning. The fourth commenter thought the provision required the hospital to implement the discharge plan.

Response: We have decided to revise this paragraph to use the statutory language to allay any confusion. As revised, the regulations require the hospital to arrange for the initial implementation of the Medicare patient discharge plan.

Comment: Two commenters stated that we should specify in regulations the format and content of the discharge plan.

Response: We do not believe it desirable to specify a single format and content for a discharge plan. Discharge planning is a discipline with competing theories and practices, each of which likely carries with it unique documentation procedures and formats. We believe the hospital should retain flexibility in deciding the plan's format and content. As our experience with this requirement develops and as needed, we will develop and revise interpretive guidelines for survey personnel to assist them in assessing the sufficiency of an acceptable discharge plan.

Comment: Two commenters thought we ought to require the hospital to furnish a written discharge plan to the patient or patient representative. Two commenters would like us to require the patient or representative to sign the discharge plan to acknowledge receipt and acknowledge participation in the plan. One commenter believed we ought to require hospitals to document in the medical record the fact that the patient and family have been counseled.

Response: Although a hospital may choose to follow any of these suggestions, we do not want to encroach on its autonomy and flexibility by requiring these procedures.

Comment: One commenter believed that the patient or patient representative should have the right to a review if he or she does not approve of the discharge plan, with no financial liability during the review process. Another commenter thought that we should include specific guidance about what hospitals must tell their patients about their rights when there are disputes about discharge plans.

Response: It is the hospital's responsibility to assure there is a mechanism for handling discharge planning complaints and disputes and we believe they should have the flexibility to determine how to address these. The reassessment process in § 482.43(e) can measure how successful the hospital's procedures are.

Comment: Two commenters wanted the discharge plans to be given to patients within specified timeframes before discharge.

Response: We do not believe that establishing a specific time before discharge by which a discharge plan must be furnished would be useful. In some difficult situations, the plan may not be ready until shortly before the patient is discharged; having the plan ready too long before discharge does not allow for changing circumstances.

Comment: One commenter wanted us to require that the discharge plan be entered into the medical record.

Response: The State surveyors, in determining compliance with this condition, will look at whether the hospital developed discharge plans for patients who needed them and whether the hospital arranged for its initial implementation. The hospital will be expected to be able to document its decision about the need for a plan, document the existence of plans where they are needed and show what steps it took to implement those plans initially. In our view, the hospital has the latitude to accomplish this result in the most efficient way possible. We do not believe that the discharge plan, which may contain information already in the medical record in the form of clinical notes, for example, is always an essential part of the patient's formal medical record. We recognize that the JCAHO requires that the discharge plan be entered into the medical record, and that many hospitals may do it, but we do not believe that making this mandatory in all cases would serve a useful purpose.

Comment: Several commenters remarked about the requirement in § 482.43(c)(4) concerning periodic reassessment; one commenter thought that the reassessment should be based on changes in the patient's condition or progress. Another commenter wanted to know how the periodic reassessment differs from an assessment on an as-needed basis. The third commenter believed that the requirement, as written, could apply after discharge and the regulation needs to specify that the reassessment occurs before discharge.

Response: We are modifying proposed § 482.43(c)(4) to require reassessments on an as-needed basis, based on factors that may affect continuing care needs or the appropriateness of the discharge plan. We do not agree that the regulation needs to specify that the reassessment must be done before discharge. The duty for discharge planning ends after discharge, assuming the hospital has arranged for the initial implementation of the Medicare patient's discharge plans in accordance with § 482.43(c)(3) and has transferred or referred the patient in accordance with § 482.43(d).

Comment: One commenter wanted us to specify predetermined times at which the patient and family must be counseled to prepare for post-hospital care, rather than requiring this counseling on an as-needed basis.

Response: We do not agree that we should be so specific. Hospital personnel are in the best position to judge the best times to counsel the patient and family and to accommodate individual situations.

Comment: One commenter thought we should avoid over-utilization of family caregiving systems and use more non-family-based community resources.

Response: Use of family caregivers occurs in discharge planning only when the family is both willing *and* able to perform needed services. In the absence of such a commitment, it is appropriate to use community resources that are not family-based.

Comment: One commenter thought there is a need for greater identification of the caregiver in the discharge planning process; in each case, the commenter suggested, we should require the hospital to determine whether there is a caregiver, the caregiver's willingness and ability to provide care, and mechanisms for preparing families to provide the care. Another commenter, on the other hand, expressed concern that the regulation text inappropriately advocates the use of family caregivers in situations where community-based services are available and that we are not providing the patient his or her choice in such situations.

Response: We agree that identification of family or other caregiver is a key attribute of effective discharge planning and believe that our regulations at 42 CFR 482.43(b)(3), (b)(4), (b)(6) and (c)(5) both appropriately and in a balanced manner relate to this need.

More specific information on the role of the caregiver will be included in the interpretive guidelines, including provision of specialized instruction or training in post-hospital care.

Transfer and Referral

Comment: We received four comments on our requirement that a hospital must discharge or transfer the patient after executing a discharge plan. One commenter thought we were going beyond the intent of the statute and that few hospitals have the authority to transfer or refer patients; one thought our statement that the statute did not require discharge or transfer to be misleading; and two commenters were in favor of the provision.

Response. While it is true that the statute does not explicitly require the hospital to follow through and actually discharge or transfer the patient, we believe the requirement is implicit in the purpose of the legislation: to assure that patients receive proper post-hospital care. This requirement, as with other conditions of participation, must operate within the constraints of a hospital's authority under State law and within the limits of a patient's right to refuse discharge planning services. As we stated in the preamble to the proposed rule, the proposed requirement is *not* new and has been in place for some time.

Comment: One commenter remarked that we should strengthen the regulation by requiring hospital discharge planning personnel to maintain complete and accurate information on community long-term care services and facilities for advising patients and their representatives of their options.

Response: We do not believe a change in the regulation is warranted. The current outcome-oriented standard is sufficient and in accord with the regulatory approach used in the June 17, 1986 revision to the conditions of participation for hospitals. Hospitals will be able to choose from many methods to demonstrate compliance with the standard. We will incorporate the commenter's suggested language in the interpretive guidelines for the standard and for the on-going reassessment of the hospital's discharge planning process required in § 482.43(e).

Comment: One commenter questioned whether § 482.43(d), which requires the hospital to transfer necessary medical information along with the patient for post-hospital services, is compatible with § 482.24(b)(3), which requires release of information only to authorized individuals.

Response: 42 CFR 482.24(b)(3) requires that the hospital have a procedure for insuring confidentiality of patient records. Information from or copies of records must be released only to authorized individuals and the hospital must ensure that unauthorized individuals cannot gain access to or alter patient records. Original medical records must be released by the hospital only in accordance with Federal or State laws, court orders, or subpoenas.

Since proposed § 482.43(d) has been in effect as § 482.21(b)(2) (beginning September 15, 1986), there has been no conflict with § 482.24(b)(3) and we do not anticipate any problems when § 482.43(d) becomes effective as a final rule. "Necessary medical information" has not been interpreted in our guidelines as requiring transmission of the patient's medical record.

Comment: One commenter wanted to know how a hospital decides what an appropriate facility is and what information is necessary to send to it.

Response: "Appropriate facilities" refers to facilities that can meet the patient's medical needs on a post-discharge basis. Our interpretive guidelines for § 482.21(b)(2) give as examples of "necessary" information: functional capacity of an individual, the nursing and other care requirements of the patient, discharge summary, and referral forms.

Comment: One commenter asked who pays the photocopy costs for the information transferred with the patient to post-hospital services.

Response: These are typical overhead costs of Medicare hospital operations that are allocated to the appropriate cost center and that are already taken into account as part of the cost base used to develop payment rates under the prospective payment system (PPS). Therefore, the PPS payment rates already reflect these costs and no additional payment by either Medicare or the beneficiary is needed.

Comment: One commenter inquired what authority the patient or patient representative has to limit the transmission of medical information required under § 482.43(d).

Response: If the information is governed by § 482.24(b)(3), which concerns medical record services, it is subject to the safeguards of that provision. This provision requires that medical information be released only to authorized individuals and that the hospital ensure that unauthorized individuals cannot gain access to or alter patient records. Otherwise the release of the information is governed by any other Federal law, State law or hospital policy, which may require a patient's written authorization before release of information.

Comment: One commenter requested that we define "appropriate facility" as one that (a) is able to provide needed care in a manner that complies with Federal and State standards; (b) participates in payment programs that are needed to pay for the beneficiary's care; and (c) is within a reasonable distance of the beneficiary's home so that relatives and friends may visit. Such a definition, the commenter suggested, would establish reasonable guidelines consistent with current HCFA policies and Congressional intent.

Response: The term "appropriate facility" has been utilized in present 42 CFR 482.21(b)(2) since September 15, 1986 without further definition and has not presented an implementation problem. Therefore, we do not believe we need a more specific definition in this regulation. Our interpretive guidelines for § 482.21(b)(2) currently define "appropriate facilities" as facilities that can meet the patient's medical needs on a post-discharge basis. We will consider the commenter's suggested factors, and others, when drafting implementing guidelines for § 482.43(d).

Comment: One commenter suggested that we require at least one post-hospital follow-up by the discharge planning staff.

Response: Although it may be desirable to do a follow-up, we believe that it is beyond the scope of our statutory authority to require it.

Reassessment

Comment: One commenter thought we should reinforce the requirement in § 482.43(e) that a hospital reassess its discharge planning process on an on-going basis; the reinforcement would be a requirement that a hospital document its discharge planning process, the procedure and the results of the reassessment.

Response: As stated in response to comments on the general opening statement in § 482.43, we are requiring that the hospital have written policies and procedures for its entire discharge planning process, which will include its reassessment. A specific documentation requirement for § 482.43(e) is not needed since it is subsumed by our revision of the general opening statement in § 482.43. We will also reinforce the need for documentation of § 482.43(e) in our interpretive guidelines.

Comment: One commenter believed it would be helpful if the new hospital condition of participation for discharge planning had built into it measures or parameters for ascertaining when additional discharge planning features and responsibilities should be added.

Response: Although we do not agree that such measures or parameters should be specified in the regulation at this time, or that they could be all inclusive, we do believe it is appropriate to mention some factors suggested by commenters to the regulations that will be included in the interpretive guidelines for § 482.43(e). The guidelines will include assuring—

(1) The effectiveness of the identification criteria;

(2) The quality and timeliness for discharge planning evaluations and discharge plans;

(3) That the hospital discharge personnel maintain complete and accurate information on community long-term care services and facilities and use this information to advise patients and their representatives of appropriate options; and

(4) That the hospital has a coordinated discharge planning process that integrates discharge planning with other functional departments, including the quality assurance and utilization review activities of the institution, and involves the various disciplines responsible for patient care.

Also, in reviewing this and other comments, we believe § 482.43(e) can be strengthened by clarifying that, although a review of discharge plans must be part of the reassessment requirement, we are not restricting a hospital to that mechanism alone. For example, a hospital might wish to review a sample of patients who were not identified as likely to suffer adverse health consequences upon discharge if there was no adequate discharge planning as a means to reassess the effectiveness of their identification criteria. This clarification of the regulation will remove an unnecessary restriction on the means used to accomplish reassessment and increase hospital flexibility in meeting the reassessment standard. Section 482.43(e) is revised to read:

> The hospital must reassess its discharge planning process on an ongoing basis. This reassessment must include a review of discharge plans to ensure that they are responsive to discharge needs.

Miscellaneous

Comment: One commenter thought it unfortunate that the two interrelated processes (the development of uniform needs assessment instruments and discharge planning) have been separated.

Response: Although these two statutory provisions both appear in section 9305 of OBRA '86, they are separate provisions (section 9305(c) is the hospital discharge planning process and section 9305(h) is the development of uniform needs assessment instrument(s)) with different implementation requirements. The legislation does not specify that implementation of the hospital discharge planning process is contingent upon development of a uniform needs assessment instrument. Further, implementation of the hospital discharge planning process requires regulations only while section 9305(h) required the appointment of and public hearings by a Secretary's Advisory Panel on the Development of Uniform Needs Assessment Instrument(s), which was to send a report to Congress with its recommendations. The 18-member

panel completed its work, and the recommendations were forwarded to Congress in a report on June 30, 1992. The recommendations to Congress include recognition of the need for field testing and possible further refinement of the uniform needs assessment instrument before adoption. Certainly, patients have a current need for an expanded discharge planning process under the hospital conditions of participation and we do not believe an additional delay of this rule would serve a useful purpose.

The commenter may be assured that, although these are separate statutory provisions with separate implementation requirements, HCFA has and will continue to coordinate these two activities. The discharge planning process has been structured so that any future instrument requirements can be incorporated by regulation into the discharge planning requirements. Similarly, the Advisory Panel drafted the framework of the uniform needs assessment instrument that they believe is compatible with this rule on discharge planning. It is premature, however, to include a requirement for usage of the instrument in the condition of participation before the instrument's utility is evaluated through field testing.

Comment: One commenter believed we should mandate the training of all discharge planning personnel in the use of the uniform needs assessment instrument when it is developed.

Response: The Secretary submitted a report on the uniform needs assessment instrument to Congress on June 30, 1992. The report includes recommendations on the appropriate use of the instrument. At the present time it would be premature to require such training.

Comment: One commenter thought we should include direction on how to determine whether someone has been authorized to act on the patient's behalf, as there may be disputes concerning post-hospital care.

Response: We believe it is best left to the hospital and physician to handle these disputes within the limits of an applicable State statute. It would be very difficult for us to draft guidelines that are flexible enough to allow all appropriate hospital procedures to be approved and, since the Federal interest is in the result rather than the process, we elected to leave this to hospital discretion.

Comment: We received comments from three entities concerning the "Important Message from Medicare." All three thought the Message to be inadequate for purposes of informing patients of discharge planning. One commenter believed the Message should have been released at a time that did not preclude public input on the contents of the revised Message concerning discharge planning. Another commenter thought that patients should, in addition to written notification, be informed orally of their discharge planning rights.

Response: The statute does not require notice to patients concerning their right to discharge planning. It does require unconditionally that the hospital provide the service when needed. Moreover, we do not agree that the Message is inadequate for bringing discharge planning to the attention of patients or their representatives. Although it does not contain the specifics of the proposed rule as one commenter recommended, its purpose is to emphasize the availability of discharge planning and the need to consult one's physician or appropriate hospital staff for assistance. To add more detail would, we believe, add confusion; the Message is already full of other important information and could become overwhelming.

Comment: Three commenters believe we should provide more specific guidelines.

Response: There is a need, recognized by Congress, to provide for sufficient flexibility in the requirements for them to be applied to both small rural facilities and complex urban hospital centers. This approach is also consistent with the focus of the June 17, 1986 revision of the conditions of participation for hospitals, which eliminated unnecessary regulations and replaced specific details on maintaining adequate and safe facilities with general comprehensive statements.

We will implement this regulation through interpretive guidelines, which are the survey tools used by surveyors to determine Federal compliance with the regulation. These guidelines will contain a degree of specificity and clarification that is impractical and unwarranted for inclusion in the Federal regulation.

Comment: Two commenters thought we should adopt the more detailed and strict discharge planning requirements of a particular State or locality in the regulations at 42 CFR 483.43.

Response: There is nothing in the regulations to prevent a hospital from complying with stricter State or local requirements. In fact, our regulations at 42 CFR 482.11 would require such compliance. However, we believe that the statutory provision on discharge planning, because it is so detailed, reflects the level of effort intended by the Congress to be required by HCFA and so we do not believe it is appropriate to go beyond Federal statutory provisions.

Comment: One commenter believed that the regulations should clearly state that if a patient does not want a discharge evaluation or plan, his wishes should prevail over the hospital's need to comply with the condition of participation.

Response: As with other services offered by hospitals, patients may refuse to accept discharge planning or to comply with a discharge plan just as they may refuse medical treatment. When a patient exercises this choice, however, we suggest that the hospitals document the patient's refusal. The interpretive guidelines will mention this type of situation.

Comment: One commenter believed the condition of participation for discharge planning needs to reflect more comprehensively the purposes of discharge planning, among them—

(1) to ensure that patients are not discharged prematurely and to provide evidence on that point;

(2) to facilitate appropriate outplacement;

(3) to document the need for post-hospital care for purposes of prior concurrent authorization by fiscal intermediaries to pay for such services;

(4) to document the need for administratively necessary days; and

(5) to help ensure continuity of cases in a fragmented delivery system.

Response: As defined in the legislation, the purpose of the discharge planning process is to ensure a timely and smooth transition to the most appropriate type and setting for post-hospital or rehabilitative care. The regulations include requirements to achieve this result. We do not believe a more detailed discussion of its purpose would enhance its effect.

Comment: One commenter believed that we should require that each hospital have an integrated discharge planning process.

Response: Assuring that the process is complete and functions properly is a hospital's responsibility. The interpretive guidelines for § 482.43(e) contain procedures for determining a hospital's success in meeting this requirement. We believe that a separate regulatory requirement for "coordination" would be redundant.

Comment: One commenter thought we should include a requirement that discharge planning be placed within the hospital's social services department.

Response: We do not agree. One of our stated objectives of the revised conditions of participation for hospitals, which became effective September 15, 1986, was to permit maximum

flexibility in hospital administration and they do not contain a requirement for a social services department into which this requirement could be placed. We will continue to encourage that flexibility in implementing the discharge planning requirement by not requiring that it be placed in a particular hospital department.

Comment: One commenter stated that there is a need for careful monitoring and vigorous enforcement of the discharge planning process.

Response: We agree. As with the other conditions of participation, the new 42 CFR 482.43 will be monitored through the survey and certification process. We will be developing detailed guidelines for our hospital surveyors to use in determining whether the discharge planning process results in the development of appropriate plans; whether the individual plans are adequate; and whether the plans are appropriately executed as required by this regulation.

V. Summary of Revisions to Proposed Rule

We are adopting the proposed rule as final with the changes described above. These changes include the following:

- Section 482.43, Introductory paragraph: We are revising this section to specify that the hospital discharge planning condition of participation applies to all patients, and we are adding a requirement that the hospital must specify its discharge planning policies and procedures in writing.
- Section 482.43 (b)(2) and (c)(1)—We are omitting the phrase "(consistent with available community and hospital resources)."
- Section 482.43(b)(5)—We are omitting the qualifier, ", to the greatest extent possible," from the requirement that appropriate arrangements be made before discharge.
- Section 482.43(c)(3)—We are requiring the hospital to arrange for the initial implementation of the discharge plan rather than requiring that a hospital assist in implementing a discharge plan.
- Section 482.43(c)(4)—We are requiring the hospital to reassess a patient's discharge plan if there are factors that may affect continuing care needs or the appropriateness of the discharge plan, rather than requiring the proposed periodic reassessment.
- Section 482.43(e)—We are revising the proposed requirement that a hospital reassess its discharge planning process by reviewing discharge plans to instead include review of the plans as part of the reassessment.

Also, as noted in section III. B of this preamble, we are not adopting the proposed changes in §§ 405.2135 and 405.2137 to the ESRD conditions for coverage.

VI. Other Revisions

A. Medical Director

1. Background

Section 1861(e)(3) of the Act requires a hospital participating in Medicare to have by-laws in effect concerning its staff of physicians. The staff of physicians is also a matter of health and safety for the hospital's patients; therefore, section 1861(e)(9) of the Act, which gives the Secretary the authority to promulgate health and safety standards, serves as a basis for governing the appointment of a medical director.

Among the conditions of participation a hospital participating in Medicare must meet is one at § 482.22 concerning medical staff. One of the standards, concerning medical staff organization and accountability (see § 482.22(b)(3)), requires that the responsibility for the organization and conduct of the medical staff be assigned only to an individual doctor of medicine or osteopathy. This person is the medical director.

On December 19, 1989, the Omnibus Budget Reconciliation Act of 1989 (OBRA '89) (Pub. L. 101–239) was enacted. Section 6025 of that law permits a Medicare-participating hospital the flexibility to consider and assign a doctor of dental surgery or dental medicine when naming a medical director, if permitted by State law of the State in which the hospital is located.

2. Revision

As a result of section 6025 of OBRA '89, we are revising standard (b)(3), Medical staff organization and accountability, of § 482.22, Condition of participation: Medical staff. We are requiring that the responsibility for organization and conduct of the medical staff may be assigned only to an individual doctor of medicine or osteopathy, except when State law of the State in which the hospital is located permits a hospital to have a doctor of dental surgery or dental medicine as its medical director.

We are revising our regulations to conform to the OBRA '89 provision. Doing so will give hospitals flexibility in some States, eliminate conflicts between State and Federal laws in some instances, and acknowledge changing practices in the delivery of medical care.

B. Accrediting Program Name Change

The name of the entity accrediting programs for x-ray technologists in § 405.1413, Conditions for Coverage—qualifications, orientation and health of technical personnel, paragraph (a)(1), has been changed from "the Council on Medical Education" to "the Committee on Allied Health Education and Accreditation." We are making the necessary conforming change to our regulations.

VII. Impact Statement

We generally prepare a regulatory flexibility analysis that is consistent with the Regulatory Flexibility Act (RFA) (5 U.S.C. 601 through 612) unless the Secretary certifies that a final rule will not have a significant economic impact on a substantial number of small entities. For purposes of the RFA, we treat all hospitals and ESRD facilities as small entities.

We do not have the data to assess accurately the magnitude of the change in procedures that will result from the new condition of participation on discharge planning. However, we believe that adequate planning is already done in most hospitals for the following reasons:

- The prospective payment system has created an incentive for hospitals to have good discharge planning procedures; and
- The conditions of participation have a standard requiring each hospital to do discharge planning.

In the absence of positive evidence to the contrary, we believe that this final rule will have little effect. We wish to point out, however, that incorporating the statutory requirements as a condition, instead of a standard, could result in graver consequences for those hospitals that do not engage in adequate planning in the event that a routine or complaint survey establishes noncompliance. However, we do not expect this to happen often.

If it were correct to presume that a lack of planning leads to systematic underservice of beneficiary needs, then the requirement for discharge planning, especially early assessment of the need for planning, should:

- Ensure that needs are identified and appropriate transfers and referrals are made; and
- Result in some increase in health care utilization by patients who might otherwise not have received needed care.

We do not believe that all patients receive all needed care. However, factors other than the lack of planning affect whether or not patients receive

needed services. Even when planning is available, patients sometimes defer or avoid recommended referrals or follow-up care.

The other provisions of this rule will have no significant effect.

We have determined and the Secretary certifies that this final rule will not have a significant economic impact on a substantial number of small entities. We have therefore not prepared a regulatory flexibility analysis.

Section 1102(b) of the Social Security Act requires the Secretary to prepare a regulatory impact analysis if a final rule may have a significant impact on the operations of a substantial number of small rural hospitals. Such an analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 50 beds.

We are not preparing a rural impact statement since we have determined, and the Secretary certifies, that this final rule will not have a significant impact on the operations of a substantial number of small rural hospitals.

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

VIII. Paperwork Reduction Act

Section 482.43 of this rule contains information collection requirements that are subject to the Office of Management and Budget (OMB) approval under the Paperwork Reduction Act of 1980 (44 U.S.C. 3504, *et seq.*). The reporting burden for the collections of information in § 482.43 is comparable to the burden for § 482.21(b), which it replaces (and which is currently approved under OMB approval number 0938–0328).

IX. Waiver of Proposed Rulemaking

The Administrative Procedure Act (5 U.S.C. 553) requires us to publish a general notice of proposed rulemaking in the **Federal Register** and afford prior public comment on proposed rules. Such notice includes a statement of the time, place and nature of rulemaking proceedings, reference to the legal authority under which the rule is proposed rule or a description of the subjects and issues involved. However, this requirement does not apply when the agency finds good cause that such a notice and comment procedure is impracticable, unnecessary, or contrary to the public interest, and incorporates its reasons in the rules issued.

We have in this final rule published our intent to conform our requirements on medical director qualifications to those of section 6025 of Public Law 101–239 and to change the name of an accrediting program. Since this final rule merely conforms our regulations regarding medical director qualifications to the statute without interpretation, and the change of name of an accrediting program only amends the regulations to reflect the new name, we believe it to be unnecessary and not in the public interest to publish a proposed rule to obtain public comment.

List of Subjects

42 CFR Part 405

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

42 CFR Part 482

Administrative practice and procedure, Certification of compliance, Contracts (Agreements), Health care, Health facilities, Health professions, Hospitals, Laboratories, Medicare, Onsite surveys, Outpatient providers, Reporting requirements, Rural areas, X-rays.

42 CFR Chapter IV is amended as set forth below:

A. Part 405, subpart N, is amended as follows:

PART 405—FEDERAL HEALTH INSURANCE FOR THE AGED AND DISABLED

1. The authority citation for subpart N continues to read as follows.

Authority: Secs. 1102, 1861(s)(3), (11) and (12), 1864, and 1871 of the Social Security Act (42 U S C. 1302, 1395x(s)(3), (11), and (12), 1395aa and 1395hh).

Subpart N—Conditions for Coverage of Portable X-ray Services

§ 405.1413 [Amended]

2. Section 405.1413(a)(1) is amended by revising the name of "the Council on Education" to "the Committee on Allied Health Education and Accreditation."

B. Part 482 is amended as follows:

PART 482—CONDITIONS OF PARTICIPATION FOR HOSPITALS

1. The authority citation for part 482 continues to read as follows:

Authority: Secs. 1102, 1136, 1138, 1814(a)(6), 1861 (e), (f), (r), (v)(1)(G), (z), and (ee), 1864, 1871, 1883, 1886, 1902(a)(30), and 1905(a) of the Social Security Act (42 U.S.C. 1302, 1320b–6, 1338, 1395f(a)(6), 1395x (e), (f), (k), (r), (v)(1)(G), (z), and (ee), 1395aa, 1395hh, 1395tt, 1395ww, 1396a(a)(30), and 1396(a)).

2. Section 482.21(b) is revised as follows:

§ 482.21 Condition of participation: Quality assurance.

* * * * *

(b) *Standard: Medically-related patient care services* The hospital must have an ongoing plan, consistent with available community and hospital resources, to provide or make available social work, psychological, and educational services to meet the medically-related needs of its patients.

3. In § 482.22(b), the introductory text is republished and paragraph (b)(3) is revised to read as follows:

§ 482.22 Conditions of participation: Medical staff.

* * * * *

(b) *Standard: Medical staff organization and accountability.* The medical staff must be well organized and accountable to the governing body for the quality of the medical care provided to patients.

* * * * *

(3) The responsibility for organization and conduct of the medical staff must be assigned only to an individual doctor of medicine or osteopathy or, when permitted by State law of the State in which the hospital is located, a doctor of dental surgery or dental medicine.

4. A new § 482.43 is added as follows.

§ 482.43 Condition of participation: Discharge planning.

The hospital must have in effect a discharge planning process that applies to all patients. The hospital's policies and procedures must be specified in writing.

(a) *Standard: Identification of patients in need of discharge planning* The hospital must identify at an early stage of hospitalization all patients who are likely to suffer adverse health consequences upon discharge if there is no adequate discharge planning.

(b) *Standard: Discharge planning evaluation.*

(1) The hospital must provide a discharge planning evaluation to the patients identified in paragraph (a) of this section, and to other patients upon the patient's request, the request of a person acting on the patient's behalf, or the request of the physician.

(2) A registered nurse, social worker, or other appropriately qualified personnel must develop, or supervise the development of, the evaluation.

(3) The discharge planning evaluation must include an evaluation of the

likelihood of a patient needing post-hospital services and of the availability of the services.

(4) The discharge planning evaluation must include an evaluation of the likelihood of a patient's capacity for self-care or of the possibility of the patient being cared for in the environment from which he or she entered the hospital.

(5) The hospital personnel must complete the evaluation on a timely basis so that appropriate arrangements for post-hospital care are made before discharge, and to avoid unnecessary delays in discharge.

(6) The hospital must include the discharge planning evaluation in the patient's medical record for use in establishing an appropriate discharge plan and must discuss the results of the evaluation with the patient or individual acting on his or her behalf.

(c) *Standard: Discharge plan.*

(1) A registered nurse, social worker, or other appropriately qualified personnel must develop, or supervise the development of, a discharge plan if the discharge planning evaluation indicates a need for a discharge plan.

(2) In the absence of a finding by the hospital that a patient needs a discharge plan, the patient's physician may request a discharge plan. In such a case, the hospital must develop a discharge plan for the patient.

(3) The hospital must arrange for the initial implementation of the patient's discharge plan.

(4) The hospital must reassess the patient's discharge plan if there are factors that may affect continuing care needs or the appropriateness of the discharge plan.

(5) As needed, the patient and family members or interested persons must be counseled to prepare them for post-hospital care.

(d) *Standard: Transfer or referral.* The hospital must transfer or refer patients, along with necessary medical information, to appropriate facilities, agencies, or outpatient services, as needed, for followup or ancillary care.

(e) *Standard: Reassessment.* The hospital must reassess its discharge planning process on an on-going basis. The reassessment must include a review of discharge plans to ensure that they are responsive to discharge needs.

(Catalog of Federal Domestic Assistance Programs No. 93 778, Medical Assistance Program, No. 93 773, Medicare—Hospital Insurance Program; No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: November 23, 1994.

Bruce C. Vladeck,

Administrator, Health Care Financing Administration

Approved: December 5, 1994.

Donna E. Shalala,

Secretary.

[FR Doc. 94–30555 Filed 12–12–94, 8:45 am]

BILLING CODE 4120–01–P

42 CFR Parts 412 and 413

[BPD–802–CN]

RIN 0938–AG46

Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 1995 Rates; Correction

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

ACTION: Final rule; correction.

SUMMARY: In the September 1, 1994 issue of the **Federal Register** (59 FR 45330), we published a final rule with comment period revising the Medicare hospital inpatient prospective payment systems for operating costs and capital-related costs to implement necessary changes arising from our continuing experience with the system. In the addendum to that final rule with comment period, we announced the prospective payment rates for Medicare hospital inpatient services for operating costs and capital-related costs applicable to discharges occurring on or after October 1, 1994, and set forth update factors for the rate-of-increase limits for hospitals and hospital units excluded from the prospective payment systems. This notice corrects errors made in that document.

EFFECTIVE DATE: October 1, 1994

FOR FURTHER INFORMATION CONTACT: John Davis—Wage Index (410) 966–5654, Nancy Edwards—Other Issues (410) 966–4531.

SUPPLEMENTARY INFORMATION: In the September 1, 1994 final rule with comment period (59 FR 45330), we indicated that if a hospital believes its wage index value is incorrect as a result of an intermediary or HCFA error, the hospital must notify HCFA no later than September 23, 1994. As a result of this process, we have identified several corrections to the wage data. Accordingly, the wage index values for several areas have been changed.

The final rule also contained other technical and typographical errors. The revised wage index values, and other changes affecting prospective payment rates, reflect corrections that were made between publication of the FY 1995 prospective payment system final rule with comment period on September 1, 1994, and implementation of the FY 1995 prospective payment rates on October 1, 1994. Therefore, we are making the following corrections to the September 1, 1994 final rule with comment period:

1. On page 45361, the chart at the top of the page is corrected as follows:

Percentage change in area wage index value	Number of labor market areas		Corrected number of labor market areas	
	FY 1995	FY 1994	FY 1995	FY 1994
Increase more than 10 percent	2	13	5	13
Increase between 5 and 10 percent	4	24	17	24
Decrease between 5 and 10 percent	13	58	13	58
Decrease more than 10 percent	10	14	10	14

2. On pages 45421 through 45436, the following entries in Table 3C—Hospital Case Mix Indexes for Discharges Occurring in Federal Fiscal Year 1993; Hospital Average Hourly Wage for Federal Fiscal Year 1995 Wage Index—are corrected as follows:

Provider	Case mix index	Avg. hour wage	Corrected avg. hour wage
050030	01.3478	17.25	17.31
050153	01.6323	26.54	26.63
050183	01.1897	18.72	19.77