

List of Subjects in 21 CFR Part 1308

Administrative practice and procedure, Drug traffic control, Narcotics, Prescription drugs.

Under the authority vested in the Attorney general by section 201(a) of the CSA [21 U.S.C. 811(a)], and delegated to the Administrator of the DEA by the Department of Justice regulations (28 CFR 0.100) and redelegated to the Deputy Administrator pursuant to 28 CFR 0.104, the Acting Deputy Administrator hereby amends 21 CFR part 1308 as follows:

PART 1308—[AMENDED]

1. The authority citation for 21 CFR part 1308 continues to read as follows:

Authority: 21 U.S.C. 811, 812, 871(b) unless otherwise noted.

2. Section 1308.14 is amended by redesignating the existing paragraph (e)(10) as (e)(11) and adding a new paragraph (e)(10) to read as follows:

§ 1308.14 Schedule IV.

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(e) * * *

(10) Sibutramine1675

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Dated: February 5, 1998.

Peter F. Gruden,

Acting Deputy Administrator.

[FR Doc. 98-3439 Filed 2-10-98; 8:45 am]

BILLING CODE 4410-09-M

DEPARTMENT OF DEFENSE**Office of the Secretary****32 CFR Part 397****Removal of Part**

AGENCY: Department of Defense.

ACTION: Final rule.

SUMMARY: This document removes obsolete information in Title 32 of the Code of Federal Regulations addressing the organizational establishment of the Defense Printing Service. This part has served the purpose for which it was intended in the CFR and is no longer necessary.

EFFECTIVE DATE: February 11, 1998.

FOR FURTHER INFORMATION CONTACT: L. Bynum or Patricia Toppings, 703-697-4111.

SUPPLEMENTARY INFORMATION:**List of Subjects in 32 CFR Part 397**

Organization and functions.

PART 397—[REMOVED]

Accordingly, by the authority of 10 U.S.C. 301, 32 CFR part 397 is removed.

Dated: February 5, 1998.

L.M. Bynum,

Alternate OSD Federal Register Liaison Officer, Department of Defense.

[FR Doc. 98-3351 Filed 2-10-98; 8:45 am]

BILLING CODE 5000-04-M

DEPARTMENT OF HEALTH AND HUMAN SERVICES**Health Care Financing Administration****42 CFR Parts 412 and 413**

[HCFA-1731-F]

RIN 0938-AG00

Medicare Program; Payment for Preadmission Services

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

ACTION: Final rule.

SUMMARY: This final rule responds to public comments on the January 12, 1994, interim final rule with comment period that provided that inpatient hospital operating costs include certain preadmission services furnished by the hospital (or by an entity that is wholly owned or operated by the hospital) to the patient up to 3 days before the date of the patient's admission to that hospital. These provisions implement amendments made to section 1886(a)(4) of the Social Security Act by section 4003 of the Omnibus Budget Reconciliation Act of 1990.

EFFECTIVE DATE: These regulations are effective on March 13, 1998.

FOR FURTHER INFORMATION CONTACT: Sandy Hetrick, (410) 786-4542.

SUPPLEMENTARY INFORMATION:**I. Background**

Section 1886 of the Social Security Act (the Act) addresses Medicare payment for hospital inpatient operating costs. Before the enactment of section 4003 of Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508), section 1886(a)(4) of the Act defined the operating costs of inpatient hospital services to include "all routine operating costs, ancillary service operating costs, and special care unit operating costs with respect to inpatient hospital services as such costs are determined on an average per admission or per discharge basis * * *." In 1966, the Medicare program established an administrative policy regarding payment for services furnished before

admission to a hospital. Specifically, if a beneficiary with coverage under Medicare Part A was furnished outpatient hospital services and was thereafter admitted as an inpatient of the same hospital before midnight of the next day, our longstanding policy provided that outpatient hospital services furnished to the beneficiary were treated as inpatient services and included in the hospital's Part A payment.

When the prospective payment system for hospitals was implemented in 1983, the costs related to the longstanding policy concerning the payment for preadmission outpatient services as inpatient services were included in the base year costs used to calculate the standardized payment amount and the diagnosis-related group (DRG) weighting factors. (Hospitals excluded from payment under the prospective payment system continue to be paid for inpatient hospital services they furnish, as well as for the preadmission services described above, on the basis of reasonable costs up to the ceiling on the allowable rate of the increase for Medicare hospital inpatient operating costs, as set forth in the Act.) Therefore, these preadmission services could not be billed separately from the covered inpatient admission that follows, since payment for them was included in the payment made under Part A for the inpatient stay (that is, the DRG payment for hospitals under the prospective payment system or, for excluded hospitals, the reasonable cost payment subject to the rate-of-increase limit).

Section 4003(a) of Pub. L. 101-508 amended the statutory definition of "operating costs of inpatient hospital services" at section 1886(a)(4) of the Act to include the costs of certain services furnished prior to admission. These preadmission services are to be included in the Part A payment for the subsequent inpatient stay. As amended, section 1886(a)(4) of the Act defines the operating costs of inpatient hospital services to include certain preadmission services furnished by the hospital (or by an entity that is wholly owned or operated by the hospital) to the patient up to 3 days before the date of the patient's admission to the hospital.

The provisions of section 4003(b) of Public Law 101-508 provided for implementation of the 3-day payment window in the following three phases:

- The first phase, effective from November 5, 1990 (the enactment date of Public Law 101-508) through September 30, 1991, included any services furnished during the day before the date of admission regardless of

whether the services are related to the admission.

- The second phase, which was effective on January 1, 1991, and is ongoing, includes diagnostic services (including clinical diagnostic laboratory tests) that are furnished during the 3 days immediately preceding the date of admission.

- The third phase, which was effective October 1, 1991, and is ongoing, includes other services related to the inpatient admission that are furnished during the 3 days immediately preceding the date of admission.

On January 12, 1994, we published an interim final rule with comment period (59 FR 1654) implementing section 4003 of Pub. L. 101-508. To implement this provision, we revised the regulations at 42 CFR 412.2(c) for prospective payment hospitals and § 413.40(c)(2) for hospitals excluded from the prospective payment system. At the time of publication of the interim final rule, the 3-day payment window applied to hospitals under the prospective payment system as well as to excluded hospitals.

Since publication of the interim final rule, section 1886(a)(4) was further amended by section 110 of the Social Security Act Amendments of 1994 (Pub. L. 103-432). That amendment revised the payment window for hospitals excluded from the prospective payment system to include only those services furnished during the 1 day (not 3 days) before a patient's hospital admission. In the September 1, 1995 final rule containing changes to the hospital inpatient prospective payment system, we revised § 413.40(c)(2) of the regulations to provide for the 1-day payment window for hospitals and hospital units excluded from the prospective payment system (60 FR 45840). We also noted that the term "day" refers to the calendar day immediately preceding the date of admission, not the 24-hour time period that immediately precedes the hour of admission. (In this document, we will continue to refer to the provision as the "3-day payment window" with the understanding that, for excluded hospitals, the applicable period of the window is 1 day, not 3.)

II. Provisions of the Interim Rule With Comment Period

In the January 12, 1994 interim final rule with comment period, we specified that payment for inpatient operating costs includes certain preadmission services furnished by the hospital or by an entity wholly owned or operated by the hospital to the patient during the 3

days immediately preceding the date of the patient's admission. We revised §§ 412.2(c)(5) and 413.40(c)(2) to provide that a hospital is considered the sole operator of an entity if the hospital has exclusive responsibility for conducting or overseeing the entity's routine operations, regardless of whether the hospital also has policymaking authority over the entity. In addition, we stated that ambulance services are excluded from preadmission services subject to the payment window. Finally, in §§ 412.2(c)(5)(ii) and 413.40(c)(2)(ii), we defined "services related to the admission" as those non diagnostic services that are furnished in connection with the principal diagnosis assigned to the inpatient admission. We specifically invited comment on several other approaches to defining "services related to the admission." We suggested the following four alternatives:

- Presume that all services provided during the 3 days before admission are related.
- Presume that certain services are never related to the admission, for example, chronic maintenance dialysis.
- Develop an inclusive list of services that are medically related, against which all claims could be electronically screened.
- Define services related to the principal diagnosis to include any services that fall within the same major diagnostic category (MDC).

III. Discussion of Public Comments

We received 11 comments in response to the interim final rule published on January 12, 1994. The majority of the comments we received responded to our definition of services related to the inpatient admission and, thus, subject to the payment window. We received four comments in support of our determination that ambulance services are not subject to the payment window, even when furnished during the preadmission period by the admitting hospital or by an entity that it wholly owns or operates. One commenter expressed agreement with our statement that ambulance services are distinct from the type of hospital services that Congress designed the payment window provision to address. All four commenters stated that many hospitals that operate ambulance services do so at a financial loss, and that hospitals continue to furnish the ambulance services primarily as a means of ensuring access to hospital care for individuals who otherwise would be unable to reach hospitals. According to the commenters, subjecting hospitals that operate ambulance services to still

greater fiscal constraints under the payment window provision could have a major adverse impact on their availability, particularly in remote rural areas. We also received several comments suggesting that there are other services that should always be excluded from the payment window.

Comment: We received three comments that questioned whether the 3-day payment window provision was intended to apply to home health services. One national organization made the point that home health agencies should be exempt from these provisions on much the same basis that ambulance services are. That is, home health services were never included in the hospital inpatient payment. Therefore, they could not be part of the services that hospitals have sought to unbundle in order to maximize payment.

Two commenters believed that it is unfair to single out hospital-based home health agencies for this provision while independent agencies would be exempt. The commenters also believed that it would be difficult to determine if the condition for which the home health agency provided treatment is related to the admitting diagnosis and that home health agencies would not know at the time they provided a service that it would be subject to the payment window. They pointed out that home health agencies have separate provider numbers and that their bills are processed by regional fiscal intermediaries; accordingly, including home health services on the payment window would greatly increase administrative burden on both the provider and the fiscal intermediaries.

Response: We agree with the commenters that home health services are distinct from the types of services that Congress intended to address in the payment window provision. The House Budget Committee Report accompanying the payment window legislation explained that the underlying objective of this provision is " * * * to curb further unbundling which has occurred since the introduction of the DRG payment system. * * * " (H.R. Budget Committee Report No. 881, 101st Cong., 2d Sess. 250 (1990).) That report further states that the services included in the window are not separately reimbursable under Part B. Home health services are generally covered under Part A and, thus, generally are not paid under Part B. Therefore, we are clarifying that services provided by home health agencies are excluded from the payment window provisions. In addition, we are clarifying that this exclusion extends to

other services provided under Part A, that is, services furnished by skilled nursing facilities and hospices. We have revised the regulations at §§ 412.2(c)(5) and 413.40(c)(2) to reflect this policy. We note that diagnostic services provided by these facilities that would be payable under Part B are subject to the window.

Comment: Three commenters requested that maintenance renal dialysis not be subject to the payment window. These commenters noted that patients must have dialysis on an ongoing basis. Because most patients receive dialysis three times a week, for any hospitalization, the patient will have at least one dialysis treatment falling in the payment window period. Regardless of the reason for the hospitalization, the patient would have received the dialysis treatment.

One of the commenters expressed the opinion that inclusion of dialysis services in the payment window provision would increase administrative costs for hospital-owned dialysis units because, prior to billing, they would have to research the diagnosis involved in every hospitalization and decide whether or not it is "related to dialysis." The commenter stated that, in such cases, dialysis units might seek payment or credit from the hospital rather than from Medicare, and that this would disrupt billing patterns and subject hospital-owned units to still greater fiscal constraints in the form of further administrative costs. Another commenter believes that excluding all outpatient chronic maintenance dialysis treatments would be easy to implement and administer. A simple directive could be issued to all Medicare contractors with instructions that dialysis services are not subject to the payment window provision.

Response: We agree with the commenters that outpatient chronic renal dialysis services are distinct from the type of hospital services that Congress designed the payment window provision to address. Maintenance dialysis must be provided to patients on a scheduled basis as long as they suffer from end-stage renal disease. Thus, it is not an inpatient service that hospitals have attempted to move outside the inpatient stay and corresponding hospital prospective payment. Therefore, in this rule, we are revising §§ 412.2(c) and 413.40(c) to exclude maintenance renal dialysis services from the preadmission services that are subject to the payment window.

Comment: Only one commenter responded to our request for comment on different approaches to defining "services related to the inpatient

admission." The commenter suggested that one possible approach would be to define certain preadmission services that are never considered to be related to the admission. The commenter provided the following list of preadmission services (in addition to maintenance renal dialysis) that should always be considered not related to the subsequent admission:

- Outpatient chemotherapy.
- Blood transfusions for chronic conditions (e.g., hemophilia and renal failure).
- Physical therapy, occupational therapy, speech therapy, other types of rehabilitative therapy, and respiratory therapy for chronic or long-term care conditions.
- Radiation therapy.

In addition, the commenter believed that any diagnostic tests associated with these services should also be excluded from the window.

Response: We agree with the commenter that certain services should not be subject to the provisions of the payment window. As noted above, we have determined that Part A services (such as home health, hospice, and skilled nursing facility services), ambulance services, and chronic maintenance renal dialysis should be excluded from the payment window.

With regard to the additional services requested by the commenter to be added to that list, we are not persuaded that these services should be excluded from the payment window. Outpatient chemotherapy and radiation therapy are time-limited treatments for specific medical conditions. This is also true of the rehabilitation services listed by the commenter. We do not believe that these services fall into the same category as maintenance dialysis. We are also not convinced that blood transfusions for chronic conditions should be excluded. These transfusions are often related to a change in condition or an injury; unlike dialysis, they are not generally provided to patients on a weekly schedule. Therefore, we are not adding any of these services to our list of exclusions. We note that we have defined services as being related to the admission only when there is an exact match between the ICD-9-CM diagnosis code assigned for both the preadmission services and the inpatient stay. Concerning the request to exclude diagnostic services associated with excluded services, we believe that the statute requires that all diagnostic services be included in the payment window.

Comment: One commenter stated that the hospital industry is making new arrangements for the provision of health care. Many hospitals are establishing

facilities licensed as free-standing clinics, owned and operated under a corporate umbrella, with a hospital responsible for conducting or overseeing the clinic's routine operations. The commenter requested that we address the difficulty of converting outpatient charges for preadmission testing from the HCFA-1500 to the UB-92 inpatient hospital billing form.

Response: We believe that the current procedures for billing Medicare for preadmission services, as set forth in section 415.6 of the Medicare Hospital Manual (HCFA-Pub. 10), are clear. When services are furnished within the 3-day payment window, they are included on the Part A bill, the HCFA-1450 (also known as the UB-92), for the inpatient stay. They are not separately billed under Part B. The charges, revenue codes, and ICD-9-CM diagnosis and procedure codes are all included on the HCFA-1450.

In the context of this comment concerning hospital arrangements, we would like to address the numerous telephone and written inquiries we have received concerning the definition of an entity "wholly owned or operated" by the hospital. The inquiries we have received include descriptions of various ownership/operation arrangements and requests to verify whether or not the 3-day payment window applies to each case. In general, if a hospital has direct ownership or control over another entity's operations, then services provided by that other entity are subject to the 3-day window. However, if a third organization owns or operates both the hospital and the entity, then the window provision does not apply. The following are examples of how this general policy is applied.

Arrangement: A hospital owns a physician clinic or a physician practice that performs preadmission testing for the hospital.

Policy: A hospital-owned or hospital-operated physician clinic or practice is subject to the payment window provision. The technical portion of preadmission diagnostic services performed by the physician clinic or practice must be included in the inpatient bill and may not be billed separately. A physician's professional service is not subject to the window.

Arrangement: Hospital A owns Hospital B, which in turn owns Hospital C. Does the payment window apply if preadmission services are performed at Hospital C and the patient is admitted to Hospital A?

Policy: Yes. We would consider that Hospital A owns both Hospital B and Hospital C, and the payment window would apply in this situation.

Arrangement: Corporation Z owns Hospitals A and B. If Hospital A performs preadmission services and the patient is subsequently admitted as an inpatient to Hospital B, are the services subject to the payment window?

Policy: No. The payment window does not apply to situations in which both the admitting hospital and the entity that furnishes the preadmission services are owned by a third entity. The payment window includes only those situations in which the entity furnishing the preadmission services is wholly owned or operated by the admitting hospital itself.

Arrangement: A hospital refers its patient to an independent laboratory for preadmission testing services. The laboratory does not perform testing by arrangement with the admitting hospital. Are the laboratory services subject to the payment window provisions?

Policy: No. The payment window does not apply to situations in which the admitting hospital is not the sole owner or operator of the entity performing the preadmission testing.

Arrangement: Hospital A is owned by Corporations Y and Z in a joint venture. Corporation Z is the sole owner of Hospital B. Does the payment window apply when one of these hospitals furnishes preadmission services and the patient is admitted to the other hospital?

Policy: No. As noted above, the payment window provision does not apply to situations in which both the admitting hospital and the entity that furnishes the preadmission services are owned or operated by a third entity.

Arrangement: A clinic is solely owned by Corporation Z and is jointly operated by Corporation Z and Hospital A. Does the payment window apply if preadmission services are furnished by the clinic and the patient is subsequently admitted to Hospital A?

Policy: No. The payment window does not apply because Hospital A is neither the sole owner nor operator of the clinic.

Comment: We received one comment on our interpretation of the statutory language of section 1886(a)(4) of the Act. The commenter asserted that we are reading the statute incorrectly, arguing that the statute requires us to include in the payment window only those diagnostic services related to the admission rather than all diagnostic services furnished during the 3 days preceding an inpatient admission. The commenter believes that since section 1886(a)(4) of the Act, as amended, reads, “if such services are diagnostic services (including clinical diagnostic laboratory tests) or are other services related to the

admission” (emphasis added), Congress meant that both diagnostic and nondiagnostic services must be related to the admission in order to be subject to the payment window. The commenter claims that the use of the word “other” in “other services related to the admission” clearly indicates that the qualifier “related to the admission” also applies to the first type of services listed, diagnostic services. The commenter stated that by including all diagnostic services in the 3-day window, we could be unfairly denying hospitals payment for separate treatment that they have furnished.

In addition, the commenter believes that our interpretation is contrary to Congressional intent since the House Budget Committee Report states that the purpose of the provision is to “curb further unbundling which has occurred since the introduction of Medicare’s hospital DRG payment system.” (H.R. Budget Comm. Rep. No. 881, 101st Cong., 2d Sess. 250 (1990).) The commenter contends that since Congress expanded the definition of “operating costs of inpatient hospital services” as part of the legislation, it sought to prevent hospitals from unbundling services that traditionally were included in an inpatient hospital stay and had been included when the initial DRG rates were set.

The commenter also asserted that the way Congress worded the three-phase implementation period of the payment window legislation proves that the legislation was intended to apply only to diagnostic services related to the admission. Therefore, the commenter believes that both diagnostic and nondiagnostic services must be related to the admission in order to be subject to the window.

Response: We believe that our reading of the statute is the proper one. Section 1886(a)(4) of the Act, as amended, defines “operating costs of inpatient hospital services” to include certain preadmission services “if such services are diagnostic services (including diagnostic laboratory tests) or are other services related to the admission (as defined by the Secretary).” (Emphasis added.) We believe that the phrase “related to the admission” modifies the term “other services” and not “diagnostic services.”

A careful reading of the statute demonstrates that our interpretation is the most natural reading of the statute, if not the only reasonable one. It is significant that the language includes the word “are” after the word “or.” The subject that relates to this use of the word “are” is “such services.” Thus, the payment window includes certain

services “if such services are diagnostic services (including diagnostic laboratory tests) or [such services] are other services related to the admission (as defined by the Secretary).” The most natural reading of this language is that the phrase “related to the admission” modifies only “other services.” In fact, it is difficult to see how this language is consistent with the commenter’s reading.

The commenter argues that *all* services must be “related to the admission” to be included in the payment window. If Congress had intended that result, Congress could have simply referred to “services related to the admission” in section 1886(a)(4) of the Act. It would not have been necessary for Congress to refer separately to diagnostic services related to the admission and other services related to the admission.

Even if the statute is not entirely clear, our interpretation is certainly consistent with the language. Similarly, our interpretation is consistent with the statutory language concerning the transition from a 1-day window to a 3-day window. For these reasons, we believe our interpretation of section 1886(a)(4) is the proper one, if not the only reasonable one.

We note that, in Pub. L. 103-342, enacted on October 31, 1994, Congress amended section 1886(a)(4) to clarify application of the payment window to services furnished by hospitals excluded from the prospective payment system, but did not address application of the window to diagnostic services. If Congress had disagreed with our interpretation concerning diagnostic services—as reflected in the interim final rule published on January 12, 1994—Congress could have further amended the statute to clarify its intent.

Finally, we would like to address the commenter’s statement that, by including all diagnostic services in the 3-day payment window, we could be unfairly denying hospitals payment for separate treatment that they have furnished. The vast majority of diagnostic services furnished by a hospital, or an entity it owns or operates, to a patient who is admitted to that hospital within 3 days are services that are related to the admission. Thus, we believe there are few diagnostic services unrelated to the admission for which hospitals would be unable to receive a separate payment.

IV. Provisions of the Final Regulations

In this final rule, we are adopting the provisions as set forth in the interim final rule with comment period with two revisions. Specifically, as a result of

public comments, we are revising the regulations as follows:

- We are revising paragraphs (c)(5) and (c)(5)(i) of § 412.2 and paragraphs (c)(2) and (c)(2)(i) of § 413.40 to provide that Part A services furnished by home health agencies, skilled nursing facilities, and hospices are excluded from the payment window provisions.
- We are revising § 412.2(c)(5)(iii) and § 413.40(c)(2)(iii) to exclude outpatient maintenance dialysis services from the preadmission services that are subject to the payment window.

V. 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 we certify that a final rule such as this will not have a significant economic impact on a substantial number of small entities. For purposes of the RFA, we consider all hospitals to be small entities.

In the interim final rule with comment period, we discussed in detail the impact that implementation of section 4003 of Public Law 101-508 would have on hospitals. Section 4003 amended section 1886(a)(4) of the Act to include certain preadmission services, furnished by the hospital, or by an entity that is wholly owned or operated by the hospital, up to 3 days before the date of the patient's admission. We stated that the interim final rule would result in continuing Medicare program savings from terminating separate payment under Part B for services performed up to 3 days before the date of admission instead of 1 day, without an immediate, corresponding increase in the DRG payments under Part A. We also noted that the interim final rule would result in some savings to beneficiaries by shifting payment for services from Part B outpatient to Part A inpatient rates. Beneficiaries will not be responsible for copayment if the same services are performed up to 3 days before the date of a hospital admission and are folded into the hospital's inpatient payment. This final rule will not have a significant impact for purposes of the RFA because it merely responds to comments on the interim final rule and makes a few clarifying changes. Therefore, we have not prepared a regulatory flexibility analysis.

Section 1102(b) of the Social Security Act requires us to prepare a regulatory impact analysis for any final rule that may have a significant impact on the operation 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 believe the 3-day payment window provisions will affect small rural hospitals to a lesser degree than larger facilities where complex procedures are performed and specialized medical conditions are treated requiring additional preadmission testings. Therefore, we are not preparing a rural impact statement since we have determined, and certify, 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 reviewed by the Office of Management and Budget.

VI. Collection of Information Requirements

This document does not impose information collection and recordkeeping requirements. Consequently, it need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995.

List of Subjects

42 CFR Part 412

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

42 CFR Part 413

Health facilities, Kidney diseases, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

Accordingly, the interim rule amending 42 CFR chapter IV which was published at 59 FR 1654, on January 12, 1994, is adopted as final with the following changes:

A. Part 412 is amended as follows:

PART 412—PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES

1. The authority citation for part 412 continues to read as follows:

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

Subpart A—General Provisions

2. In § 412.2, the introductory text of paragraph (c) is republished and paragraph (c)(5) is revised to read as follows:

§ 412.2 Basis of payment.

* * * * *

(c) *Inpatient operating costs.* The prospective payment system provides a payment amount for inpatient operating costs, including—

* * * * *

(5) Preadmission services otherwise payable under Medicare Part B furnished to a beneficiary during the 3 calendar days immediately preceding the date of the beneficiary's admission to the hospital that meet the following conditions:

(i) The services are furnished by the hospital or by an entity wholly owned or operated by the hospital. An entity is wholly owned by the hospital if the hospital is the sole owner of the entity. An entity is wholly operated by a hospital if the hospital has exclusive responsibility for conducting and overseeing the entity's routine operations, regardless of whether the hospital also has policymaking authority over the entity.

(ii) For services furnished after January 1, 1991, the services are diagnostic (including clinical diagnostic laboratory tests).

(iii) For services furnished on or after October 1, 1991, the services are furnished in connection with the principal diagnosis that requires the beneficiary to be admitted as an inpatient and are not the following:

(A) Ambulance services.

(B) Maintenance renal dialysis.

* * * * *

B. Part 413 is amended as follows:

PART 413—PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END-STAGE RENAL DISEASE SERVICES; OPTIONAL PROSPECTIVELY DETERMINED PAYMENT RATES FOR SKILLED NURSING FACILITIES

1. The authority citation for part 413 continues to read as follows:

Authority: Secs. 1102, 1861(v)(1)(A), and 1871 of the Social Security Act (42 U.S.C. 1302, 1395x(v)(1)(A), and 1395hh).

Subpart C—Limits on Cost Reimbursement

2. In § 413.40, paragraph (c)(2) is revised to read as follows:

§ 413.40 Ceiling on the rate of increase in hospital inpatient costs.

* * * * *

(c) Costs subject to the ceiling. * * *

* * * * *

(2) Preadmission services otherwise payable under Medicare Part B

furnished to a beneficiary during the calendar day immediately preceding the date of the beneficiary's admission to the hospital that meet the following conditions:

(i) The services are furnished by the hospital or any entity wholly owned or operated by the hospital. An entity is wholly owned by the hospital if the hospital is the sole owner of the entity. An entity is wholly operated by a hospital if the hospital has exclusive responsibility for conducting and overseeing the entity's routine operations, regardless of whether the hospital also has policymaking authority over the entity.

(ii) For services furnished after January 1, 1991, the services are diagnostic (including clinical diagnostic laboratory tests).

(iii) For services furnished on or after October 1, 1991, the services are furnished in connection with the principal diagnosis that requires the beneficiary to be admitted as an inpatient and are not the following:

(A) Ambulance services.

(B) Maintenance renal dialysis.

* * * * *

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance)

Dated: October 17, 1997.

Nancy-Ann Min DeParle,

Deputy Administrator, Health Care Financing Administration.

Dated: December 11, 1997.

Donna E. Shalala,

Secretary.

[FR Doc. 98-3362 Filed 2-10-98; 8:45 am]

BILLING CODE 4120-01-P

FEDERAL EMERGENCY MANAGEMENT AGENCY

44 CFR Part 64

[Docket No. FEMA-7678]

Suspension of Community Eligibility

AGENCY: Federal Emergency Management Agency, FEMA.

ACTION: Final rule.

SUMMARY: This rule identifies communities, where the sale of flood insurance has been authorized under the National Flood Insurance Program (NFIP), that are suspended on the effective dates listed within this rule because of noncompliance with the floodplain management requirements of the program. If the Federal Emergency Management Agency (FEMA) receives documentation that the community has adopted the required floodplain

management measures prior to the effective suspension date given in this rule, the suspension will be withdrawn by publication in the **Federal Register**.

EFFECTIVE DATES: The effective date of each community's suspension is the third date ("Susp.") listed in the third column of the following tables.

ADDRESSES: If you wish to determine whether a particular community was suspended on the suspension date, contact the appropriate FEMA Regional Office or the NFIP servicing contractor.

FOR FURTHER INFORMATION CONTACT:

Robert F. Shea Jr., Division Director, Program Implementation Division, Mitigation Directorate, 500 C Street, SW., Room 417, Washington, DC 20472, (202) 646-3619.

SUPPLEMENTARY INFORMATION: The NFIP enables property owners to purchase flood insurance which is generally not otherwise available. In return, communities agree to adopt and administer local floodplain management aimed at protecting lives and new construction from future flooding. Section 1315 of the National Flood Insurance Act of 1968, as amended, 42 U.S.C. 4022, prohibits flood insurance coverage as authorized under the National Flood Insurance Program, 42 U.S.C. 4001 *et seq.*, unless an appropriate public body adopts adequate floodplain management measures with effective enforcement measures. The communities listed in this document no longer meet that statutory requirement for compliance with program regulations, 44 CFR part 59 *et seq.* Accordingly, the communities will be suspended on the effective date in the third column. As of that date, flood insurance will no longer be available in the community. However, some of these communities may adopt and submit the required documentation of legally enforceable floodplain management measures after this rule is published but prior to the actual suspension date. These communities will not be suspended and will continue their eligibility for the sale of insurance. A notice withdrawing the suspension of the communities will be published in the **Federal Register**.

In addition, the Federal Emergency Management Agency has identified the special flood hazard areas in these communities by publishing a Flood Insurance Rate Map (FIRM). The date of the FIRM if one has been published, is indicated in the fourth column of the table. No direct Federal financial assistance (except assistance pursuant to the Robert T. Stafford Disaster Relief and Emergency Assistance Act not in connection with a flood) may legally be

provided for construction or acquisition of buildings in the identified special flood hazard area of communities not participating in the NFIP and identified for more than a year, on the Federal Emergency Management Agency's initial flood insurance map of the community as having flood-prone areas (section 202(a) of the Flood Disaster Protection Act of 1973, 42 U.S.C. 4106(a), as amended). This prohibition against certain types of Federal assistance becomes effective for the communities listed on the date shown in the last column.

The Associate Director finds that notice and public comment under 5 U.S.C. 553(b) are impracticable and unnecessary because communities listed in this final rule have been adequately notified.

Each community receives a 6-month, 90-day, and 30-day notification addressed to the Chief Executive Officer that the community will be suspended unless the required floodplain management measures are met prior to the effective suspension date. Since these notifications have been made, this final rule may take effect within less than 30 days.

National Environmental Policy Act

This rule is categorically excluded from the requirements of 44 CFR Part 10, Environmental Considerations. No environmental impact assessment has been prepared.

Regulatory Flexibility Act

The Associate Director has determined that this rule is exempt from the requirements of the Regulatory Flexibility Act because the National Flood Insurance Act of 1968, as amended, 42 U.S.C. 4022, prohibits flood insurance coverage unless an appropriate public body adopts adequate floodplain management measures with effective enforcement measures. The communities listed no longer comply with the statutory requirements, and after the effective date, flood insurance will no longer be available in the communities unless they take remedial action.

Regulatory Classification

This final rule is not a significant regulatory action under the criteria of section 3(f) of Executive Order 12866 of September 30, 1993, Regulatory Planning and Review, 58 FR 51735.

Paperwork Reduction Act

This rule does not involve any collection of information for purposes of the Paperwork Reduction Act, 44 U.S.C. 3501 *et seq.*