Adoption of Amendments to the Regulations

Accordingly, 26 CFR part 53 is amended as follows:

PART 53—FOUNDATION AND SIMILAR EXCISE TAXES

Paragraph 1. The authority citation for part 53 continues to read as follows:

Authority: 26 U.S.C. 7805.

§ 53.6011–1 [Amended]

Par. 2. In § 53.6011–1, paragraph (b) is amended by:

1. Removing from the first sentence, the language ''or 4955(a),'' and adding '', 4955(a), or 4958(a),'' in its place.

2. Removing from the last sentence, the language ''or 4955(a),'' and adding '', 4955(a), or 4958(a),'' in its place.

Par. 3. Section 53.6071–1T is added to read as follows:

§ 53.6071–1T Time for filing returns (temporary).

(a) through (e) [Reserved]. For further guidance see § 53.6071–1(a) through (e).

(f) *Taxes imposed on excess benefit transactions engaged in by organizations described in sections 501(c)(3) (except private foundations) and 501(c)(4)*—(1) *General rule.* A Form 4720 required by § 53.6011–1(b) for a disqualified person or organization manager liable for tax imposed by section 4958(a) shall be filed by that person on or before the 15th day of the fifth month following the close of such person's taxable year.

(2) *Special rule for taxable years ending after September 13, 1995, and on or before July 30, 1996.* A Form 4720 required by § 53.6011–1(b) for a disqualified person or organization manager liable for tax imposed by section 4958(a) on an excess benefit transaction occurring in such person's taxable year ending after September 13, 1995, and on or before July 30, 1996, is due on or before December 15, 1996.

Dated: December 10, 1996.

Margaret Milner Richardson,

Commissioner of Internal Revenue.

Donald C. Lubick,

Acting Assistant Secretary of the Treasury.

[FR Doc. 96–32376 Filed 12–31–96; 8:45 am]

BILLING CODE 4830–01–U

Fiscal Service

31 CFR Part 357

[Department of the Treasury Circular, Public Debt Series, No. 2–86]

Regulations Governing Book-Entry Treasury Bonds, Notes, and Bills; Determination Regarding State Statute; California

AGENCY: Bureau of the Public Debt, Fiscal Service, Treasury.

ACTION: Determination of substantially identical state statute.

SUMMARY: The Department of the Treasury is announcing that it has reviewed the State of California's recently enacted law adopting Revised Article 8 of the Uniform Commercial Code—Investment Securities (''Revised Article 8'') and determined that the state statute is substantially identical to the uniform version of Revised Article 8 for purposes of interpreting the rules in 31 CFR Part 357, Subpart B (the ''TRADES'' regulations). Therefore, the portion of the TRADES rule requiring application of Revised Article 8 if a state has not adopted Revised Article 8 will no longer be applicable for California.

EFFECTIVE DATE: January 2, 1997.

FOR FURTHER INFORMATION CONTACT: Walter T. Eccard, Chief Counsel (202) 219–3320, or Cynthia E. Reese, Deputy Chief Counsel (202) 219–3320.

SUPPLEMENTARY INFORMATION: On August 23, 1996, the Department published a final rule to govern securities held in the commercial book-entry system, now referred to as Treasury/Reserve Automated Debt Entry System (''TRADES''). 61 FR 43626.

In the commentary to the final regulations, Treasury stated that for the 28 states that had by then adopted Revised Article 8, the versions enacted were ''substantially identical'' to the uniform version for purposes of the rule. Therefore for those states, that portion of the TRADES rule requiring application of Revised Article 8 was not invoked. Treasury also indicated in the commentary that as additional states adopted Revised Article 8, notice would be provided in the Federal Register as to whether the enactments were substantially identical to the uniform version so that the federal application of Revised Article 8 would no longer be in effect for those states. Treasury adopted this approach in an attempt to provide certainty in application of the rule in response to public comments. This, the first such notice, addressed California's recent adoption of Article 8.

Treasury has reviewed the California enactment and concluded that the variations in California's statute from Revised Article 8 are minor. Therefore, Treasury has concluded that the California enactment is substantially identical to Revised Article 8. Accordingly, if either § 357.10(b) or § 357.11(a) directs a person to California, the provisions of §§ 357.10(c) and 357.11(d) of the TRADES rule are not applicable.

Dated: December 20, 1996.

Richard L. Gregg,

Commissioner of the Public Debt.

[FR Doc. 96–33274 Filed 12–31–96; 8:45 am]

BILLING CODE 4810–39–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Part 413

[BPD–788–F]

RIN 0938–AH12

Medicare Program; Electronic Cost Reporting for Skilled Nursing Facilities and Home Health Agencies

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

ACTION: Final rule.

SUMMARY: This final rule adds the requirement that, for cost reporting periods ending on or after February 1, 1997, most skilled nursing facilities and home health agencies must submit cost reports currently required under the Medicare regulations in a standardized electronic format. This rule also allows a delay or waiver of this requirement where implementation would result in financial hardship for a provider. The provisions of this rule allow for more accurate preparation and more efficient processing of cost reports.

DATES: This final rule is effective February 1, 1997. This rule is applicable for cost reporting periods ending on or after February 1, 1997.

FOR FURTHER INFORMATION CONTACT: Tom Talbott, (410) 786–4592.

SUPPLEMENTARY INFORMATION:

I. Background

Generally, under the Medicare program, skilled nursing facilities (SNFs) and home health agencies (HHAs) are paid for the reasonable costs of the covered items and services they furnish to Medicare beneficiaries. Sections 1815(a) and 1833(e) of the Social Security Act (the Act) provide that no payments will be made to a provider unless it has furnished the

information, requested by the Secretary, needed to determine the amount of payments due the provider. In general, providers submit this information through cost reports that cover a 12-month period. Rules governing the submission of cost reports are set forth in Federal regulations at 42 CFR 413.20 and 42 CFR 413.24.

Under § 413.20(a), all providers participating in the Medicare program are required to maintain sufficient financial records and statistical data for proper determination of costs payable under the program. In addition, providers must use standardized definitions and follow accounting, statistical, and reporting practices that are widely accepted in the health care industry and related fields. Under §§ 413.20(b) and 413.24(f), providers are required to submit cost reports annually, with the reporting period based on the provider's accounting year. Additionally, under § 412.52, all hospitals participating in the prospective payment system must meet cost reporting requirements set forth at §§ 413.20 and 413.24.

Section 1886(f)(1)(B)(i) of the Act required the Secretary to place into effect a standardized electronic cost reporting system for all hospitals participating in the Medicare program. This provision was effective for hospital cost reporting periods beginning on or after October 1, 1989. On May 25, 1994, we published a final rule with comment period in the Federal Register implementing the electronic cost reporting requirement for hospitals (59 FR 26960). On June 27, 1995, we published a final rule that responded to comments on the May 25, 1994 final rule with comment period (60 FR 33123).

II. Provisions of the Proposed Regulations

On December 5, 1995, we published a proposed rule in the Federal Register (60 FR 62237) that proposed to require SNFs and HHAs to submit cost reports in a standardized electronic format for cost reporting periods beginning on or after October 1, 1995. We also proposed that if a SNF or HHA believes that implementation of the electronic submission requirement would cause a financial hardship, it may submit a written request for a waiver or a delay of these requirements.

We stated that we essentially would apply the current hospital electronic cost reporting requirements to SNFs and HHAs. Hospitals participating in Medicare must submit cost reports in a uniform electronic format for cost reporting periods beginning on or after October 1, 1989. These hospital cost reports must be electronically transmitted to the intermediary in American Standard Code for Information Interchange (ASCII) format. In addition to the electronic file, hospitals were initially required to submit a hard copy of the full cost report, which was later changed to a hard copy of a one-page settlement summary, a statement of certain worksheet totals found in the electronic file, and a statement signed by the hospital's administrator or chief financial officer certifying the accuracy of the electronic file (§ 413.24(f)(4)(iii)). Further, to preserve the integrity of the electronic file, we specified procedures regarding the processing of the electronic cost report once it is submitted to the intermediary. In addition, the provider's electronic program must be able to disclose that changes have been made to the provider's as-filed cost report. We proposed to apply these same hospital electronic cost reporting requirements to SNFs and HHAs.

In the proposed rule, we discussed in detail the benefits of requiring electronic cost reports for SNFs and HHAs. The use of electronically prepared cost reports will be beneficial for SNFs and HHAs because the cost reporting software for these reports will virtually eliminate computational errors and substantially reduce preparation time. The use of cost reporting software will also save time when the provider discovers that it needs to change individual entries in the cost report.

III. Discussion of Public Comments

We received six timely comments in response to the proposed rule. The majority of the commenters supported our proposal but had some questions and concerns regarding its implementation. A summary of these comments and our responses follow:

Waivers and Exclusions

Comment. Several commenters requested clarification of the requirement for granting a waiver of electronic filing due to financial hardship. While some commenters suggested that we develop a defined set of criteria for determining when the requirement for electronic filing would impose a financial hardship on a provider, others supported our proposal of a case-by-case review of waiver requests. One commenter suggested that, in addition to financial hardship, waivers should be automatically granted for providers with low Medicare utilization.

Commenters supporting case-by-case review advised us to remain flexible in making determinations of financial hardship until we have the experience and data to determine whether set criteria are necessary. Another commenter supporting our proposal noted that most providers have, or have access to, a computer and recommended that as part of a waiver request, a provider should be required to include a statement certifying that it does not own, rent, or have access to a computer.

Commenters opposing case-by-case review were concerned that, based on hospitals' experiences with electronic filing, few waivers would be granted. These commenters asserted that it would be best to establish specific criteria for the waiver process.

Response. We do not believe that the development of specific criteria for waiver requests is appropriate. For example, a characteristic such as a provider's size alone may not necessarily be a reliable indicator that electronic cost reporting would impose a financial hardship since even the smallest SNFs and HHAs are quite likely to already be using computer equipment. Thus, we believe that an individualized review of each waiver request based on the totality of the provider's financial situation would be the most effective method for making determinations. Factors that we may consider in determining whether to grant a waiver include whether the provider has access to a computer, the provider's size, level of Medicare utilization, and financial status.

Regarding the commenters— concern that, like hospitals, few waivers will be granted for SNFs and HHAs, we wish to point out that the small number of electronic reporting waivers granted to hospitals is attributed to the small number of hospitals that have requested them. We have received only 10 waiver electronic reporting requests from hospitals (of approximately 7,000 hospitals required to file electronically) since we implemented electronic reporting. All 10 hospitals have been granted waivers. We note that hospitals must request the waiver every year. We anticipate receiving numerous requests from SNFs and HHAs. There are large differences in the financial structure between hospitals and long-term care providers. Hospitals provide many services that are not provided by SNFs and HHAs. Additionally, virtually all hospitals have, or have access to, computer equipment, which may or may not be the case for SNFs and HHAs. As we did with hospitals, we anticipate granting hardship waivers for providers with low Medicare utilization and

providers with reimbursement systems that would be too costly to program (for example, all inclusive rate providers who are not required to file electronically). Each waiver request will be handled on a case-by-case basis and waivers will be granted when a provider has documented appropriately its financial hardship.

We note that if a provider subject to the requirements and not granted a hardship exemption does not submit its cost report electronically, Medicare payments to that provider may be suspended under the provisions of sections 1815(a) and 1833(e) of the Act. These sections of the Act provide that no Medicare payments will be made to a provider unless it has furnished the information, requested by the Secretary, that is needed to determine the amount of payments due the provider under the Medicare program. Section 405.371(d) provides for suspension of Medicare payments to a provider by the intermediary if the provider fails to submit information requested by the intermediary that is needed to determine the amount due the provider under the Medicare program. The general procedures that are followed when Medicare payment to a provider is suspended for failure to submit information needed by the intermediary to determine Medicare payment are located in section 2231 of the Medicare Intermediary Manual (HCFA Pub. 13). Those procedures include timeframes for ''demand letters'' to providers. Demand letters remind providers to file timely and complete cost reports and explain possible adjustments of Medicare payments to a provider and the right to request a 30-day extension of the due date.

Comment. One commenter suggested that, to avoid unnecessary administrative costs and delays, the fiscal intermediary instead of HCFA should have responsibility for granting waiver requests.

Response. We believe that our process for making waiver determinations is the most efficient and will allow each provider seeking a waiver to receive an individualized review of its request. As explained later, we have extended the deadline for filing waiver requests. The revised process specifies that the waiver request, including supporting documentation, must be submitted to a provider's intermediary no later than 30 days after the end of the provider's cost reporting period. The intermediary will review the request and forward it, with a recommendation for approval or denial, to the HCFA central office within 30 days of its receipt of the request. HCFA central office will either approve or deny the request by response to the intermediary within 60 days of receipt of the request from the intermediary.

Comment. Some commenters expressed concern with the proposed deadline for filing waiver requests of 120 days before the end of the provider's cost reporting period. One commenter noted that the deadline should not be set before the end of the reporting period because the level of Medicare utilization can vary from month to month. Another commenter suggested that the time limits be modified to be more accommodating until HCFA has further experience with the impact of electronic cost reporting on SNFs and HHAs.

Response. We have reconsidered our proposed policy in light of these comments and the fact that we have decided to extend the due date for filing electronic cost reports in this final rule (as discussed under the section on ''Implementation Date''). We agree with the commenters that it is appropriate to allow providers a longer time period within which to submit waiver requests. We have revised § 413.24(f)(4)(v) to provide that a provider may submit a written request for delay or waiver with necessary supporting documentation to its intermediary no later than 30 days after the end of its cost reporting period.

Comment. One commenter suggested that in lieu of a waiver, we should allow the hardware and software costs as ''below the line'' cost expenses by modifying the Medicare cost report to allow the provider to enter the software costs directly into reimbursable costs and to treat the hardware similarly, as a capital expense.

Response. The use of electronic cost reporting software and the costs associated with it is similar to a provider hiring an accounting firm to complete its cost report. We do not make separate payments for these types of costs; rather we include the costs as administrative and general costs. Similarly, for those providers that have to purchase computer equipment, in accordance with existing regulations governing payment of provider costs, Medicare will pay for the cost of the equipment as an overhead cost.

Comment. One commenter inquired about the effect of the rule on hospital-based HHAs. The commenter asked if hospital-based facilities will be required to submit a separate cost report. Another commenter requested clarification as to whether providers under the prospective payment system would be required to file electronically. Specifically, the commenter asked that we clarify our statement in the proposed rule that a SNF that furnishes fewer than 1,500 Medicare covered days in a cost reporting period would not be subject to the electronic cost reporting requirement (60 FR 62238).

Response. The electronic cost reporting provision will only apply to those providers that are required to file a full Medicare cost report. Providers that are required to file less than a full cost report (that is, low or no Medicare utilization) will not file electronically but will be required to request a waiver of the requirement to file electronically. Hospital-based SNFs and HHAs file electronically through the hospital, would continue to do so, and would not file separately as a result of this regulation. We did not intend to exclude SNFs that are paid prospectively and that file their cost reports on Form 2540S. While § 413.321 defines the Form 2540S as a simplified cost reporting form, the form does not meet the definition of a less than full cost report as discussed above. Absent a waiver, these SNFs will be required to file their cost reports electronically. Software will be available from HCFA and from commercial vendors that meet the requirements for electronic filing.

Implementation Date

Comment. Commenters were concerned that the proposed implementation date for filing electronic cost reports beginning on or after October 1, 1995, was too aggressive and would not allow sufficient time for providers with short period cost reports to file electronically.

Response. We agree that the proposed implementation date should be revised. The new effective date will be timed to coincide with the completion of the installment of and training on the free software and electronic specifications. We anticipate that the software will be ready for distribution in time for providers to become accustomed to using it before they submit their cost reports for cost reporting periods ending on or after February 1, 1997. Thus, we are revising the implementation date to require SNFs and HHAs to begin filing their cost reports electronically for cost reporting periods ending on or after February 1, 1997. We believe that this revised implementation date will avoid prolonged extensions for short period cost reports. We also believe that providers with cost reporting periods ending on February 1, 1997 (and who thus must file their cost reports by June 30, 1997), will have ample time to do what is needed to file an electronic cost report by June 30, 1997.

Cost Reporting Software

Comment. One commenter inquired about how providers will be paid for the cost of the electronic cost reporting software. Other commenters questioned the adequacy of the software offered by HCFA and its efficiency in performing electronic filing. These commenters' concerns were based on the difficulties experienced by hospitals in using the cost reporting software provided by HCFA. Another commenter suggested that the software be available at least 6 months before the implementation date for electronic filing to allow providers time to install the software and train staff. Additionally, one commenter advised that free software should be available for SNFs under the prospective payment system. Finally, commenters suggested that we develop software for billing and for the Provider Cost Report Reimbursement Questionnaire (Form 339).

Response. HCFA will provide software, free of charge, to any provider that requests it. Alternatively, providers may purchase the software from any HCFA-approved software vendor. To obtain the free software, providers may contact their intermediaries or send a written request to the following address: Health Care Financing Administration, Division of Cost Principles and Reporting, Room C5–02–23, Central Building, 7500 Security Boulevard, Baltimore, MD 21244–1850. We note that, as with the cost of computer equipment, Medicare will pay for the cost of the software as an overhead cost through the cost report based on Medicare utilization.

Regarding commenters' concerns about the adequacy of the cost reporting software, we note that while there were some difficulties with application of the free software for hospitals, the hospital cost report is extremely complex and requires extensive reporting for a number of Medicare services that are not provided by SNFs and HHAs. Thus, we do not anticipate having similar types of problems with cost reporting software for SNFs and HHAs because these providers generally file less complicated cost reports. The free software will not be developed to compete with commercial software packages. Rather, the software offered by HCFA will enable a provider with access to a computer to meet the requirements by filing an electronic data set to the fiscal intermediary in order to generate a cost report. We expect that the software will be a series of input screens that are designed to assimilate the cost reporting forms. Once the prescribed data are entered, these same data can be forwarded to the intermediary to produce a completed cost report. As stated above, we anticipate that the software will be ready for distribution in time to allow providers to install the software and train staff.

While we do not currently require that providers submit bills in an electronic format, we strongly encourage electronic billing. We note that fiscal intermediaries can accept electronic bills prepared with commercially available software that meets Medicare specifications. Fiscal intermediaries also provide free software for submission of Medicare billing data. Providers should contact their intermediary's electronic billing department for information about this software. Additionally, we are currently in the process of developing a software package for the Form 339.

Audit Adjustments

Comment. One commenter questioned the provision in proposed § 413.24(f)(4)(iii), which requires that the fiscal intermediary must return the as-filed cost report to the provider for correction if it does not pass all specified edits. The commenter believed that requiring intermediaries to send rejected cost reports back to the provider would impose a burden because the provider would have to do a complete review of the cost report in order to identify and correct the error. The commenter suggested that we allow the intermediary discretion in determining whether to send a cost report back to the provider.

Response. This section provides that the intermediary must reject a cost report that does not pass all specified edits. This provision is not intended to prohibit the intermediary from making audit adjustments to the provider's cost report. Rather, an intermediary must reject a cost report that fails a ''level one'' edit (for example, when the settlement amount on the hard copy cost report and the amount contained in the electronic file are different). Cost reports that fail level one edits result in incorrect settlement data that cannot be corrected by the intermediary for legal reasons. The cost report is the submission of the provider and must maintain its originality throughout the cost report settlement process.

Comment. One commenter recommended that intermediaries not require providers to submit more than one hard copy of the cost report in addition to the electronic file.

Response. During a transition period, we will require providers to submit a hard copy of the completed full cost report forms in addition to the electronic file (as we did for hospitals). Requiring a hard copy will allow the provider and the intermediary to compare data on the hard copy cost report to data in the electronic file to ensure accuracy and proper programming. Once providers and intermediaries become accustomed to the use of the electronic cost reporting software, we will no longer require that a hard copy of the full cost report be filed. After the transition period, SNFs and HHAs subject to the electronic reporting requirement will be required to file a hard copy of the one-page settlement sheet, a statement of certain worksheet totals found in the electronic file, and a statement signed by their administrator or chief financial officer certifying the accuracy of the electronic file.

IV. Provisions of the Final Rule

In this final rule we are adopting the provisions as proposed with three revisions. Specifically, in response to a public comment, we are revising § 413.24(f)(4) (ii) and (iv) to change the implementation date. These sections now provide that, effective for cost reporting periods beginning on or after February 1, 1997, SNFs and HHAs must submit cost reports in a standardized electronic format. Additionally, we are revising § 413.24(f)(4)(v) to clarify that providers with low or no Medicare utilization may request a waiver of electronic cost reporting. We are making another revision to § 413.24(f)(4)(v) to specify that a provider may submit a written request for a delay or a waiver with necessary supporting documentation to its intermediary no later than 30 days after the end of its cost reporting period.

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, all providers and small businesses that distribute cost-report software to providers are considered small entities. HCFA's intermediaries are not considered small entities for purposes of the RFA.

In addition, 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 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.

As stated above, under §§ 413.20(b) and 413.24(f), providers are required to submit cost reports annually, with reporting periods based on the provider's accounting year. This final rule will require SNFs and HHAs, like hospitals, to submit their Medicare cost reports in a standardized electronic format. We anticipate that this requirement will take effect for cost reporting periods ending on or after February 1, 1997, meaning that the first electronic cost reports will be due June 30, 1997.

Currently, approximately 75 percent of all SNFs and HHAs submit a hard copy of an electronically prepared cost report to the intermediary. We believe that the provisions of this final rule will have little or no effect on these providers, except to reduce the time involved in copying and collating a hard copy of the report for intermediaries. In addition to the 75 percent of providers that currently use electronic cost reporting, this rule will not affect those providers that do not file a full cost report and, as stated above, will not be required to submit cost reports electronically.

This final rule may have an impact on those providers who do not prepare electronic cost reports, some of whom may have to purchase computer equipment, obtain the necessary software, and train staff to use the software. However, as discussed below, we believe that the potential impact of this final rule on those providers who do not prepare electronic cost reports will be insignificant.

First, a small number of providers that do not submit electronic cost reports may have to purchase computer equipment to comply with the provisions of this final rule. However, even among the 25 percent of SNFs and HHAs that do not submit electronically prepared cost reports, we believe that most providers already have access to computer equipment, which they are now using for internal record keeping purposes, as well as for submitting electronically generated bills to their fiscal intermediaries, for example. Thus, we do not believe that obtaining computer equipment will be a major obstacle to electronic cost reporting for most providers. For those providers that will have to purchase computer equipment, we note that, in accordance with current regulations governing payment of provider costs, Medicare will pay for the cost of the equipment as an overhead cost.

We recognize that a potential cost for providers that do not submit electronic cost reports will be that of training staff to use the software. Since most SNFs and HHAs currently use computers, we do not believe that training staff to use the new software will impose a large burden on providers. An additional cost will be the cost of the software offered by commercial vendors. However, providers could eliminate this cost by obtaining the free software from HCFA.

The requirement that hospitals submit cost reports in a standardized electronic format has been in place since October 1989. Since that time, the accuracy of cost reports has increased and we have received very few requests for waivers. Additionally, we have not received any comments from the hospital industry indicating that the use of electronic cost reporting is overly burdensome. We believe that electronic cost reporting will be equally effective for SNFs and HHAs, with the benefits (such as increased accuracy and decreased preparation time) outweighing the costs of implementation for most providers.

In conclusion, we have determined that this final rule will not have a significant effect on SNF and HHA costs because these providers will not be required to collect any additional data beyond that which the regulations currently specify; cost reporting software is available at no cost from HCFA to any provider that requests it; most SNFs and HHAs have some type of computer equipment through which they currently prepare electronic cost reports; and a waiver of the electronic cost reporting requirement will be available to providers for whom the requirement will impose a financial hardship. We note that, as with the cost of computer equipment, Medicare will pay for the cost of the software as an overhead cost through the cost report based on Medicare utilization. Therefore, SNFs and HHAs will only be affected to the extent that, absent a waiver, they will be required to submit cost reports in a standardized electronic format to their intermediary. A provider that does not comply with the provisions of this rule, as specified in the preamble, will be subject to sections 1815(a) and 1833(e) of the Act, which provide that no payments will be made to a provider unless it has furnished the information requested by the Secretary that is needed to determine the amount of payments due the provider under Medicare.

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

VI. Collection of Information Requirements

The overall information collection and recordkeeping requirements associated with filing HHA costs reports (HCFA Form 1728) have been approved by OMB through October 1997 (OMB approval number 0938–0022). Additionally, OMB has approved the overall information collection and record keeping requirement associated with filing SNF costs reports (HCFA Form 2540) through May 1999 (OMB approval number 0938–0463).

This final rule does not require SNFs and HHAs to report any information on the electronic cost report that is not already required in the Medicare cost reports currently submitted by these providers. Although this regulation does not impose any new information collection requirements per se, the new electronic format requires HCFA to resubmit the information collection requirements to OMB for approval.

We estimate that the number of hours each provider will save by submitting an electronically prepared cost report instead of manually preparing and photocopying the cost report will be about 4.5 hours for each affected HHA and 9 hours for each affected SNF. Assuming that approximately 25 percent of all SNFs and HHAs will be affected, that is, roughly 3,000 SNFs and 2,000 HHAs, we estimate that SNFs will save approximately 27,000 hours per year completing cost reports and HHAs will save about 9,000 hours per year.

This final rule does not need to be reviewed by OMB under the Paperwork Reduction Act of 1995.

List of Subjects in 42 CFR Part 413

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

42 CFR part 413 is amended as set forth below:

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).

2. Section 413.1 is amended by redesignating paragraphs (a)(1)(ii) (C) through (J) as paragraphs (a)(1)(ii) (D) through (K), respectively, and adding a new paragraph (a)(1)(ii)(C) to read as follows:

§ 413.1 Introduction.

(a) *Basis, scope, and applicability.*

(1) *Statutory basis.* * * *

(ii) *Additional requirements.* * * *

(C) Sections 1815(a) and 1833(e) of the Act provide the Secretary with authority to request information from providers to determine the amount of Medicare payment due providers.

* * * * *

3. Section 413.24 is amended by redesignating existing paragraphs (f)(4)(i) through (f)(4)(iv) as paragraphs (f)(4)(ii) through (f)(4)(v); adding a new paragraph (f)(4)(i); and revising redesignated paragraphs (f)(4)(ii) through (f)(4)(v) to read as follows:

§ 413.24 Adequate cost data and cost finding.

* * * * *

(f) *Cost reports.* * * *

(4) *Electronic submission of cost reports.* (i) As used in this paragraph, ''provider'' means a hospital, skilled nursing facility, or home health agency.

(ii) Effective for cost reporting periods beginning on or after October 1, 1989, for hospitals, and cost reporting periods ending on or after February 1, 1997, for skilled nursing facilities and home health agencies, a provider is required to submit cost reports in a standardized electronic format. The provider's electronic program must be capable of producing the HCFA standardized output file in a form that can be read by the fiscal intermediary's automated system. This electronic file, which must contain the input data required to complete the cost report and the data required to pass specified edits, is forwarded to the fiscal intermediary for processing through its system.

(iii) The fiscal intermediary stores the provider's as-filed electronic cost report and may not alter that file for any reason. The fiscal intermediary makes a ''working copy'' of the as-filed electronic cost report to be used, as necessary, throughout the settlement process (that is, desk review, processing audit adjustments, final settlement, etc). The provider's electronic program must be able to disclose if any changes have been made to the as-filed electronic cost report after acceptance by the intermediary. If the as-filed electronic cost report does not pass all specified edits, the fiscal intermediary rejects the cost report and returns it to the provider for correction. For purposes of the requirements in paragraph (f)(2) of this section concerning due dates, an electronic cost report is not considered to be filed until it is accepted by the intermediary.

(iv) Effective for cost reporting periods ending on or after September 30, 1994, for hospitals, and cost reporting periods ending on or after, February 1, 1997, for skilled nursing facilities and home health agencies, a provider must submit a hard copy of a settlement summary, a statement of certain worksheet totals found within the electronic file, and a statement signed by its administrator or chief financial officer certifying the accuracy of the electronic file or the manually prepared cost report. During a transition period, skilled nursing facilities and home health agencies must submit a hard copy of the completed cost report forms in addition to the electronic file. The following statement must immediately precede the dated signature of the provider's administrator or chief financial officer:

I hereby certify that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet Statement of Revenue and Expenses prepared by _____ (Provider Name(s) and Number(s)) for the cost reporting period beginning _____ and ending _____ and that to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(v) A provider may request a delay or waiver of the electronic submission requirement in paragraph (f)(4)(ii) of this section if this requirement would cause a financial hardship or if the provider qualifies as a low or no Medicare utilization provider. The provider must submit a written request for delay or waiver with necessary supporting documentation to its intermediary no later than 30 days after the end of its cost reporting period. The intermediary reviews the request and forwards it, with a recommendation for approval or denial, to HCFA central office within 30 days of receipt of the request. HCFA central office either approves or denies the request and notifies the intermediary within 60 days of receipt of the request.

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(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: September 27, 1996.

Bruce C. Vladeck,

Administrator, Health Care Financing Administration.

[FR Doc. 96–33093 Filed 12–31–96; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF TRANSPORTATION

National Highway Traffic Safety Administration

49 CFR Part 571

[Docket No. 74–14; Notice 110]

RIN 2127–AG14

Federal Motor Vehicle Safety Standards; Occupant Crash Protection

AGENCY: National Highway Traffic Safety Administration (NHTSA), DOT.

ACTION: Final rule; technical amendment.

SUMMARY: On November 27, 1996, NHTSA published a final rule requiring vehicles with air bags to have new warning labels. The preamble to the notice stated that one of the labels, the removable label, would have the following statement: ''Children *Can* Be KILLED or INJURED by Passenger Air Bag.'' (emphasis added) Two other labels, the sun visor warning label and the child seat label, also include statements indicating that death or injury *can* occur. Due to a typographic error, the figure in the regulatory text for the removable label indicates that the label should read: ''Children *May* Be KILLED or INJURED by Passenger Air Bag.'' (emphasis added). This notice corrects that error.

DATES: *Effective Date:* The amendments made in this rule are effective January 2, 1997.

Petition Dates: Any petitions for reconsideration must be received by NHTSA no later than February 18, 1997.

ADDRESSES: Any petitions for reconsideration should refer to the docket and notice number of this notice and be submitted to: Administrator, National Highway Traffic Safety Administration, 400 Seventh Street, SW, Washington, DC 20590.

FOR FURTHER INFORMATION CONTACT: Mary Versailles, Office of Safety Performance Standards, NPS–31, National Highway Traffic Safety Administration, 400 Seventh Street, SW, Washington, D.C. 20590; telephone