

reports, citing the exemptions presently granted for inpatient facilities (non-PPS hospitals and skilled nursing facilities). The commenter believes that this resulted in discrimination against the establishment of home health care services when the emphasis of health care is away from inpatient services and toward home care.

Response: Prior to 1987, § 413.40(f)(7) (formerly § 405.460(f)(7)) granted an exception to the cost limits to minimize financial barriers to HHAs wanting to enter Medicare markets for the first time, especially in underserved areas. On June 4, 1987, we published a final rule with comment period (52 FR 21216) indicating that the exception for newly-established HHAs was eliminated. As discussed in detail in that final rule with comment period, evidence acquired from FY 1980 through FY 1985 indicated a changing composition of HHAs that suggested that financing was no longer a significant obstacle to entering the market place, and therefore the exception was rescinded. In fact, while hospital-based and proprietary agencies had access to financial resources and patient populations, nonprofit and free-standing agencies did not. We continue to believe that an exception for newly-established HHAs is not necessary to encourage the spread of HHAs services. Moreover, we note that the number of HHAs servicing Medicare beneficiaries has increased approximately 28 percent since 1987, from 5,857 to 7,473 as of March, 1994.

Comment: Several commenters indicated that the recruitment and retention of occupational therapists and physical therapists, especially in rural areas, results in increased costs not incorporated in the HHA cost limits.

In addition, one commenter indicated that the additional amount of \$.18 allowed for the OSHA adjustment to account for new standards for universal precautions is not adequate to account for the actual, necessary and reasonable cost being incurred by HHAs after May 31, 1991.

The commenters believe that the failure to reflect these costs fully in the per-visit limits will reduce access and quality of care to beneficiaries.

Response: If a provider can quantify the costs it incurs as a result of recruiting and retaining occupational therapists or physical therapists, or an OSHA add-on amount that exceeds the allowed \$.18, the provider may apply for an exception to the cost limits under the exceptions process outlined in § 413.30. These situations could be recognized as an "extraordinary circumstances" as defined in

§ 413.30(f)(2). The HHA cost limits effective for cost reporting periods beginning on or after July 1, 1992 and on or after July 1, 1993 allow a provider an adjustment for costs incurred for OSHA, upon presentation of documentation to the intermediary to substantiate the adjustment. If a provider exceeds the adjustment, an exception to the cost limits is made only to the extent that costs are reasonable, attributable to the circumstances specified, separately identified by the provider, and verified by the intermediary.

Comment: Some of the commenters believe that filing for a waiver to seek an exception from the limits is time consuming, expensive and impractical.

Response: The purpose of establishing the per-visit limits is to cover the costs necessary in the efficient delivery of needed health services. However, because the limits are not intended to take into account every cost, we have established an exceptions process for situations in which providers incur additional costs in excess of the cost limits. Providers may apply for an exception to the cost limits under the exceptions process outlined in § 413.30. We believe that the exceptions process is a fair and equitable method for HHAs to substantiate costs exceeding the limit.

6. Administrative Procedure Act

Comment: A commenter stated that the schedule of cost limits published on July 8, 1993 (58 FR 36748) is void because it is a product of retroactive rulemaking, which is not authorized by the Social Security Act and is prohibited by the Administrative Procedure Act (APA). Specifically, the rule had an effective date of July 1, 1993, but was not published in the **Federal Register** until July 8, 1993. Further, the commenter stated that the rule is void because it was issued in violation of the notice and comment requirements of the Medicare statute and APA. The commenter believes that we did not have "good cause" to waive publication of a proposed notice and to waive the 30-day delayed effective date requirements of the APA. The commenter stated that HCFA failed to offer any explanation as to why the rule could not have been published earlier.

Response: Section 1861(v)(1)(L)(iii) of the Act requires that the Secretary update the HHA cost limits on an annual basis for cost reporting periods beginning on or after July 1 of each year. On July 1, 1993, the schedule of limits on HHA costs per visit, effective for cost reporting periods beginning on or after July 1, 1993, was filed with the Office of the Federal Register and was made

available for public inspection (see 58 FR 36762 for file date). Under 44 U.S.C. section 1507, the filing of the document is sufficient to give constructive notice of the contents of the document to a person subject to or affected by it.

As explained in our July 8, 1993 notice with comment period, we used the same methodology to develop the schedule of limits that was used in setting the limits published on July 1, 1992. The cost limits were updated to reflect the cost increases occurring between the cost reporting periods for the data contained in the database and December 31, 1993.

Because the methodology used to develop the July 1, 1993 schedule of limits was previously published for public comment and because we are required by section 1861(v)(1)(L)(iii) of the Act to use the current hospital wage index, which was based on 1988 wage survey data, we determined that it would be impractical and unnecessary to request public comment before we implemented the cost limits effective for cost reporting periods beginning on or after July 1, 1993. Thus, we stated that it would be contrary to public interest, and we found good cause to waive publication of a proposed notice.

In response to the comment on the waiver of the 30-day delayed effective date, as we explained in our July 8, 1993 notice with comment period, in order for HHAs to receive timely the benefits of the cost limits that are based on the updated wage index, it was necessary that the limits be effective for cost reporting periods beginning on or after July 1, 1993 as required by section 1861(v)(1)(L)(iii) of the Act (see 58 FR 36762).

B. Response to Public Comments Received on the January 6, 1994 Notice With Comment Period

We received 10 items of timely correspondence on our notice eliminating payment adjustments for the A&G costs of hospital-based HHAs. The comments we received on that notice and our responses to those comments are set forth below.

Many of the comments we received on that notice addressed issues that we have already addressed in section II.A of this notice, particularly, the exclusion of hospital-based agencies from the database. Since we have already addressed these comments, we are not repeating our responses to the comments here.

1. Elimination of the A&G Add-on

Comment: One commenter agreed that the A&G add-on should be eliminated. However, most commenters objected to