

and operated by one or two individuals and are often located in rural areas. They include approximately 1,500 RHCs and 1,500 FQHCs. We estimate that 1,350 of the 3000 RHCs and FQHCs may not have the necessary computer equipment. We believe, however, 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 may have to purchase computer equipment, we note that, in accordance with current regulations governing payment of provider costs, we will pay for the cost of the equipment as an overhead cost. Rural health clinics and FQHCs will be reimbursed subject to a payment limit; OPOs reimbursed based on costs; hospices reimbursed according to fee schedule; ESRDs paid a composite rate, and CMHCs will be reimbursed through a blend of prospective payment (PPS) and 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 hospices, OPOs, RHCs, FQHCs, CMHCs, and ESRD facilities 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 would be the cost of the software offered by commercial vendors. However, providers could eliminate this cost by obtaining the necessary software from us, free of charge. In those instances when these requirements may cause hardship, a waiver can be granted.

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 hospices, OPOs, RHCs, FQHCs, CMHCs, and ESRD facilities, with the benefits (such as increased accuracy and decreased preparation time) outweighing the costs of implementation for most providers.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule that may result in an expenditure

in any one year by State, local, or tribal governments, in the aggregate, or by the private sector, that exceeds the inflation-adjusted threshold of \$110 million. This rule does not impose any costs that would exceed the \$110 million threshold on the governments mentioned, or the private sector.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct compliance costs on State and local governments, preempts State law, or otherwise has Federalism implications. We have examined this final rule and have determined that this rule will not have an impact on the rights, roles, and responsibilities of State, local, or tribal governments.

In accordance with the provisions of Executive Order 12866, this final rule was reviewed by the Office of Management and Budget.

List of Subjects in 42 CFR Part 413

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

■ For the reasons set forth in the preamble, the Centers for Medicare & Medicaid amends 42 CFR chapter IV part 413 as follows:

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

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

Authority: Secs. 1102, 1812(d), 1814(b), 1815, 1833(a), (i) and (n), 1861(v), 1871, 1881, 1883, and 1886 of the Social Security Act (42 U.S.C. 1302, 1395d(d), 1395f(b), 1395g, 1395l(a), (i), and (n), 1395x(v), 1395hh, 1395rr, 1395tt, and 1395ww).

■ 2. Section 413.24 is amended by revising existing paragraphs (f)(4)(i) 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, home health agency, hospice, organ procurement organization, rural health clinic, Federally qualified health clinic, community mental health center, or end-stage renal disease facility.

(ii) Effective for cost reporting periods beginning on or after October 1, 1989 for hospitals, cost reporting periods ending on or after December 31, 1996 for skilled nursing facilities and home health agencies, and cost reporting periods ending on or after December 31, 2004 for hospices, organ procurement organizations, rural health clinics, Federally qualified health centers, community mental health centers, and end-stage renal disease facilities, a provider is required to submit cost reports in a standardized electronic format. The provider’s electronic program must be capable of producing the CMS 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 to pass specified edits, must be 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, and final settlement). 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 must return 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, cost reporting periods ending on or after December 31, 1996 for skilled nursing facilities and home health agencies, and cost reporting periods ending on or after December 31, 2004 for hospices, organ procurement organizations, rural health clinics, Federally qualified health centers, community mental health centers, and end-stage renal disease facilities, 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 (first two cost-reporting periods on or after December 31, 2004), hospices, organ procurement