gifts, bequests, or devises shall be deposited in the Treasury and shall be available for disbursement upon order of the Settlement Committee. For purposes of the Federal income, estates, and gift taxes, property accepted under this subsection shall be considered as a gift, bequest, or devise to the United States.

(c) ADMINISTRATIVE SUPPORT SERVICES.—Upon the request of the Settlement Committee, the Administrator of General Services shall provide to the Settlement Committee, on a reimbursable basis, the administrative support services necessary for the Settlement Committee to carry out its responsibilities under this Act.

(d) IMMUNITY.—The Settlement Committee is an agency of the United States for the purpose of part V of title 18, United States Code (relating to the immunity of witnesses).

(e) COMPENSATION.—Members of the Settlement Committee shall each be entitled to receive the daily equivalent of level V of the Executive Schedule for each day (including travel time) during which they are engaged in the actual performance of duties vested in the Settlement Committee.

SEC. 7. SPANISH LAND GRANT STUDY PROGRAM.

(a) The Secretary of the Smithsonian Institution and the Settlement Committee working in conjunction with the University of New Mexico, and Highlands University shall establish a Spanish Land Grant Study program with a research archive at the Oñate Center in Alcalde, New Mexico. This program shall be designed to meet the requirements of the Smithsonian Institution's Affiliated Institutions Program.

(b) The purposes of the Spanish Land Grant Study Program are to assist the Settlement Committee in the performance of its activities under section 5, and to archive and interpret the history of land distribution in the southwestern United States under Spanish and Mexican law, and the changes to this land distribution system following the transfer of territory from Mexico to the United States under the terms of the Treaty of Guadalupe-Hidalgo in 1848.

SEC. 8. TERMINATION.

The Settlement Committee shall terminate on 180 days after submitting its final report to Congress under section 5.

SEC. 9. AUTHORIZATION OF APPROPRIATIONS.

There is authorized to be appropriated $1,500,000 for each of the fiscal years 1999 through 2003 for the purpose of carrying out the activities of the Settlement Committee created in section 3, and the Spanish Land Grant Study Program created section 7.●

By Mr. BOND (for himself, Mr. GRASSLEY, Mr. LOTT, Mr. BREAUX, Mr. BURNS, Mr. MACK, Mr. BINGAMAN, Mr. FRIST, Mr. MURKOWSKI, Mrs. MURRAY, Mr. ROBERTS, Mr. HOLLINGS, Mr. DODD, Mr. FAIRCLOTH, Ms. COLLINS, Mr. JEFFORDS, Mr. THOMAS, Mr. D'AMATO, Mr. HATCH, Mr. SHELBY, Mr. ASHCROFT, Mr. KEMPTHORNE, Mr. ROBB, Mr. BAUCUS, Mr. CLELAND, Mr. CRAIG, and Mr. SANTORUM):

S.J. Res. 50. A joint resolution to disapprove the rule submitted by the Health Care Financing Administration, Department of Health and Human Services on June 1, 1998, relating to surety bond requirements for home health agencies under the Medicare and Medicaid programs; to the Committee on Finance.

RESOLUTION DISAPPROVING OF HCFA'S SURETY BOND RULE

Mr. BOND. Mr. President, today I introduce a measure on behalf of myself, Mr. BAUCUS, Mr. GRASSLEY, and others which sends a strong message to the Health Care Financing Administration (HCFA) that the United States Senate disapproves of the agency's recent rule regarding surety bond requirements for home health agencies.

The surety bond regulation, coupled with HCFA's implementation of the Interim Payment System (IPS) for home health, are crippling the ability of our Nation's home health agencies to provide high quality care to our Nation's seniors and disabled.

Over this past month alone, in St. Louis, Missouri, the two largest home health providers decided to get out of the home health business—leaving hundreds of elderly and disabled patients searching for a new provider. The invaluable, dedicated services provided by the largest independent provider in St. Louis , the Visiting Nurses Association (VNA), will no longer be realized by the approximately 600 home care patients the agency has served.

It is regrettable that a government bureaucracy is forcing a home health agency, that has served the St. Louis area for 87 years, out of the home health care business.

The Balanced Budget Act of 1997 requires that all Medicare-participating home care agencies hold surety bonds in an amount that is not less than $50,000. This provision was modeled after a successful Florida Medicaid statute which imposes surety bonds on home care providers as a way of ensuring that only reputable businesses entered Florida's Medicaid program.

This needed and modest idea, however, has been severely distorted by HCFA. HCFA's surety bond rule deviates from Florida's program in two major ways:

First, the Florida program requires a $50,000 bond. HCFA's rule requires the bond amount to be the greater of $50,000 or 15 percent of the home care agency's previous year's Medicare revenues.

Since HCFA issued its initial rule back in January of 1998, constituents in my home State have reported numerous problems in securing these bonds. These reputable individuals inform me that most bond companies are refusing to sell home care bonds under the regulation's requirements. Those few companies that are selling bonds are requiring backup collateral equal to the full face value of the bond, or personal guarantees of two or even three times the value of the bond.

Second, the Florida program requires only new home care agencies to secure these bonds. Agencies with at least one year in the program and with no history of payment problems were exempted from the bond requirement. HCFA's rule, however, requires all Medicare-participating home care agencies to hold bonds, regardless of how long an agency has been in Medicare and regardless of the agency's good Medicare history. Further, HCFA's rule requires every home care agency to purchase new surety bonds every year.

HCFA's rule is outrageous. These requirements and costs are unaffordable, especially for the smaller, freestanding home health agencies. HCFA's surety bond regulations threaten the existence of many small business home health providers and the essential services they provide to the most vulnerable and most frail of our society.

The surety bond requirement reflects HCFA's attitude that all Medicare providers are suspect. Rather than keeping unscrupulous providers out of the home health business, HCFA's rule will penalize and put many decent home health agencies out of business.

In promulgating this rule, HCFA did not consider the long-standing reputation of most home health agencies, their years of compliance with Medicare's regulations, or their history of managing and avoiding overpayments from the government. These providers have worked long and hard within the convoluted Medicare program, have abided by the rules and regulations, and have been subjected to numerous audits by fiscal intermediaries.

HCFA's careless disregard, which has already put many conscientious law-abiding companies out of business, must be dealt with immediately. It is especially incomprehensible when the small businesses at risk provide a service so valued by the disabled and older Americans who receive it.

On Tuesday, June 8, the Regulatory Fairness Board for Region VII held a public meeting in Frontenac, Missouri, a suburb of St. Louis. My Red Tape Reduction Act of 1996 created ten Regional Fairness Boards to be the eyes and ears of small business, collecting comments from small businesses on their experience with Federal regulatory agencies. The Ombudsman, created under the same law, is to use these comments to evaluate the small business responsiveness of agency enforcement actions.

According to Scott George, a small business owner from Mt. Vernon, Missouri who serves on the Region VII Fairness Board, this particular meeting of the Fairness Board was dominated by testimony from smaller, freestanding home health care agencies that will be driven out of business by the HCFA regulations. They testified that more than 1,100 home health care providers nationwide have already closed their doors this year. Mr. George noted that every company that testified before the Region VII Fairness Board said they would be driven out of business by year-end. One couple traveled from Michigan to Missouri to testify that they will be out of business by the time of the Regional Fairness Board for their area holds a hearing absent relief from the HCFA regulations.

Mr. President, concerns similar to those expressed in Missouri this Tuesday were raised with HCFA during its rulemaking. Regrettably, HCFA reacted like a quarter horse down the home stretch with blinders on, ignoring the comments submitted by small business as well as the agency's statutory obligations under the Administrative Procedures Act (APA) and the Regulatory Flexibility Act of 1980 as amended by my Red Tape Reduction Act in 1996.

In April, at the urging of myself and other Senators, the Small Business Administration's Office of Advocacy sent a letter to HCFA to advise the agency of the significant NEGATIVE impact this rule would have on small home health care providers. SBA's letter documents the deficiencies in the HCFA efforts to implement the bonding requirement. As set forth by the Chief Counsel of Advocacy, HFCA appears to have: exceeded the Congressional mandate in the Balanced Budget Act of 1997, inappropriately waived the APA's requirement for a general notice of proposed rulemaking with the opportunity for comment, and bypassed the procedural and analytical safeguards provided by the Regulatory Flexibility Act as amended by my Red Tape Reduction Act in 1996.

The SBA Office of Advocacy petitioned HCFA to exclude the provisions requiring the 15 percent bond requirement and the capitalization requirement pending a ''proper and adequate analysis'' of the impacts on small businesses. HCFA did not exclude these requirements. Not only does this exceed the scope of the 1997 Congressional directive, but it also imposes an undue financial burden on reputable home health agencies. Furthermore, in its June final rule, HCFA did not conduct a Regulatory Flexibility analysis of the rules impact on small home health care agencies. Instead, HCFA certified that the rule would not have a significant economic impact on a substantial number of small entities. HCFA's certification is in direct conflict with the comments submitted by the Office of Advocacy and the home health care industry regarding the small business impacts of the rule.

In 1996, Congress voted to enhance its ability to put a stop to excessive regulations and sloppy agency rulemakings. Enacted as Subtitle E of my Red Tape Reduction Act, the Congressional Review Act enhances the ability of Congress to serve as such a backstop. Senators NICKLES and REID sponsored the bipartisan, Congressional Review portion of the Red Tape Reduction Act to provide a new process for Congress to review and disapprove new regulations and to make sure regulators are not exceeding or ignoring the Congressional intent of statutory law.

The simple fact is that HCFA has ignored everyone—Congress, the SBA, the home health industry, and most importantly the beneficiaries of home health services. Congress must therefore move expeditiously and exercise its authority under the Congressional Review Act to pass a resolution of disapproval to strike the June 1 HCFA rule because HFCA exceeded the Congressional mandate and issued this rule in total disregard of its statutory obligations under the APA, Regulatory Flexibility Act and the Red Tape Reduction Act. Although Congress did direct the agency to develop surety bonding requirements and provide a deadline for such a rule to be issued, this does not relieve the agency of its responsibility to conduct such a rulemaking in accordance with existing laws intended to ensure procedural fairness in the rulemaking process.

The practical implication of Congress expressing its disapproval of the June rule is to require HCFA to go back and to conduct rulemaking in accordance with the intent of Congress as expressed in the Balanced Budget Act of 1997 and in keeping with the APA and the Regulatory Flexibility Act. As part of the rulemaking, HCFA should conduct an appropriate initial and final Regulatory Flexibility analysis in accordance with Sections 603 and 604 of the Regulatory Flexibility Act. Congress enacted these procedural safeguards to require agencies to assess the impact of rules such as HCFA's on small entities and to ensure that agencies choose regulatory approaches that are consistent with the underlying statute while minimizing the impacts on small entities to the extent possible. We should pass the resolution we are introducing today to ensure HCFA implements its statutory responsibilities in accordance with the law.

While I strongly support the vigorous routing of fraud and abuse whenever and wherever it is found, Congress and HCFA must ensure the highest access to appropriate, high quality home care—because in-home care is the key to fulfilling the desire of virtually all seniors to remain independent and in their own homes. Home health provides a safety net for our Nation's elderly and disabled, and Congress must ensure that these protections continue long into the future.

Many of the elderly and disabled being cared for at home would not be able to remain there if it were not for the services provided by this vital industry. We should clean up the fraud and abuse, not shut the industry or cut off these critical services.

It is clear that HCFA must be held accountable, and I look forward to working with my colleagues in beginning this process today. Mr. President, I ask unanimous consent that a SBA Office of Advocacy letter be included in the RECORD.

There being no objection, the letter was ordered to be printed in the RECORD, as follows:

U.S. SMALL BUSINESS ADMINISTRATION,
Washington, DC, April 15, 1998.

HEALTH CARE FINANCING ADMINISTRATION,
DEPARTMENT OF HEALTH AND HUMAN SERVICES,
Attn: HCFA–1152–FC, Baltimore, MD.

DEAR DOCKETS MANAGEMENT CLERK: On January 5, 1998, the Heath Care Financing Administration (HCFA) published a final rule with comment period concerning surety bond and capitalization requirements for home health care agencies (HHAs). This regulation implements the surety bond requirement for such agencies established in the Balanced Budget Act of 1997 (BBA). The regulation also imposes additional minimum capitalization requirements on the agencies and includes an additional 15 percent surety bond requirements not contained in the BBA. The goal of the BBA and this final rule is to reduce Medicare/Medicaid fraud by regulating HHAs that do not or cannot reimburse Medicare/Medicaid for overpayments.

To address complaints by the surety bond industry and the HHA industry regarding the compliance deadline for obtaining surety bonds, HCFA published a final rule on March 4, 1998 deleting the February 27, 1998 effective date for all HHAs to furnish a surety bond. The new compliance date is on or about April 28, 1998, or 60 days after publication of the final rule.

In addition, to address complaints by the surety bond industry and members of the Senate Finance Committee regarding the potentially unlimited liability of sureties under the final rule, HCFA published a Notice of Intent to Amend Regulations on March 4, 1998 (concurrently with the final rule to extend the compliance date). The notice announces HCFA's intent to amend the final rule so as to limit the surety's liability under certain circumstances. It also establishes that a surety will only remain liable on a bond for an additional two years after the date an HHA leaves the Medicare/Medicaid program; and gives a surety the right to appeal an overpayment, civil money penalty or an assessment if the HHA fails to pursue its rights of appeal. HCFA claims that the changes will help smaller, reputable HHAs, like non-profit visiting nurse associations, to obtain surety bonds.

The Office of the Chief Counsel for Advocacy of the U.S. Small Business Administration was created in 1976 to represent the views and interests of small business in federal policy making activities.[1] The Chief Counsel participates in rulemakings when he deems it necessary to ensure proper representation of small business interests. In addition to these responsibilities, the Chief Counsel monitors compliance with the Regulatory Flexibility Act (RFA), and works with federal agencies to ensure that their rulemakings demonstrate an analysis of the impact that their decisions will have on small businesses.

The Chief Counsel has reviewed the final rules in the instant case and has determined that HCFA has not adequately analyzed the impact on small entities. This determination does not mean that regulating the problem of fraud and abuse is not an important public policy objective. Nor does it mean that small business interests supersede legitimate public policy objectives. Rather, the determination is based on the principle that public policy objectives must be achieved by utilizing recognized administrative procedures. The purpose of the procedures is not to place an unnecessary burden on federal regulatory agencies, but to ensure the promulgation of common sense regulations that do not unduly discourage or destroy competition in the marketplace.

Footnotes at end of letter.

The final rule is troubling for a number of reasons: 1) The proposal, although probably within HCFA's regulatory and statutory authority, goes far beyond the requirements contemplated by Congress when they enacted the BBA; 2) HCFA's good cause exception and waiver of the proposed rulemaking may be arbitrary and capricious under the Administrative Procedure Act (APA); and 3) Nearly all of the significant procedural and analytical requirements of the RFA were overlooked.

Action requested: Inasmuch as the rule is now final and in effect, the Chief Counsel of the Office of Advocacy herewith petitions the agency, pursuant to 5 U.S.C. §553(e), to amend the final rule to exclude the provisions concerning the 15 percent bond requirement and the capitalization requirement until such time as a proper and adequate analysis can be prepared to determine the impact on small entities.

I. LEGISLATIVE HISTORY AND INTENT

Prior to August 5, 1997, there were no provisions in the law pertaining to a surety bond requirement for home health agencies. Under the House bill (The Balanced Budget Act of 1997, H.R. 2015), there remained no provisions for the surety bond requirement. Under the Senate bill (as amended) (S. 947), a requirement was introduced to provide state Medicaid agencies with surety bonds in amounts not less than $50,000. Finally, in the conference agreement, the final bill was modified to require a surety bond of not less than $50,000, or such comparable surety bond as the Secretary may permit (applicable to home health care services furnished on or after January 1, 1998).[2] Congress, therefore, intended there to be a $50,000 or ''comparable'' bond, but did not intend the bond to be higher.

The surety bond issue had not been the subject of public hearings, and some members of Congress expressed concern about the potential impact of the fraud and abuse provisions.

According to a floor statement by Senator HATCH, the fraud and abuse provisions found in the amended Senate version were actually based on provisions contained in the Administrations fraud and abuse legislation introduced earlier in 1997, and on which no hearings were held in the Senate. Senator HATCH was concerned that the fraud and abuse provisions might have ''unintended consequences or implications that would penalize innocent parties who are following the letter of the law.''[3] He further stated that, ''As a general rule, we in the Congress should not act without the full and open benefit of hearings so that all parties have an opportunity to comment, and so that legislation can be modified as appropriate.''[4] With regard to the surety bond requirement, it seems that the affected business community had no real opportunity to provide meaningful input or comment.

After the legislation was enacted, HCFA had little choice but to implement the surety bond requirement. However, the agency created additional bonding and capitalization requirements and incorporated them into the instant final rule.[5] Not only were law abiding home health agencies denied an opportunity to comment during the legislative process, they are now faced with additional burdensome requirements effective almost immediately—with no true recourse (since the agency waived the notice of proposed rulemaking and the 30-day interim effective date).

Congress clearly intended to eliminate or reduce waste and fraud in the Medicare/Medicaid system and to preserve quality patient care. The presumably unintended effects of the legislation and HCFA's final rule are that legitimate, law abiding home health agencies will be forced to file bankruptcy, go out of business or curtail their business operations significantly. Patient care will likely suffer when there are not enough home health agencies to meet increasing public demand in an aging population. Moreover, the resulting lack of market competition and bloating of the large, hospital-based and government-based home health agencies may lead to increased prices.

II. WAIVER OF ADMINISTRATIVE PROCEDURE

An agency is subject to the notice and comment requirements contained in 5 U.S.C. 553 unless the agency rule is exempt from coverage of the APA, or the agency establishes ''good cause'' for not complying with the APA and waives notice and comment. When an agency waives the notice and comment procedures required by the APA, however, there should be compelling reasons therefor. In fact, courts have held that exceptions to APA procedures are to be ''narrowly construed and only reluctantly countenanced.'' *New Jersey* v. *EPA*, 26 F.2d 1038, 1045 (D.C.Cir. 1980).

In the instant case, the agency waived both the notice and comment requirement and the requirement to allow a 30-day interim period prior to a rules effective date. The agency based its ''good cause'' waiver on three factors: 1) Issuing a proposed rule would be impracticable because Congress mandated that the effective date for the surety bond requirement be January 1, 1998 five months after Congress passed the BBA of 1997; 2) Issuing a proposed rule is unnecessary with respect to Medicare regulations because there is a statutory exception when the implementation deadline is less than 150 days after enactment of the statute in which the deadline is contained; and 3) A delay in issuing the regulations would be contrary to the public interest.

First, with regard to the impracticability of issuing a proposed rule, as a general matter, ''strict congressionally imposed deadlines, without more, by no means warrant invocation of the good cause exception.'' *Petry* v. *Block*, 737 F.2d 1193, 1203 (D.C.Cir. 1984). In addition, there is no good cause exception where an agency unwilling to provide notice or an opportunity to comment could simply wait until the eve of a statutory . . . deadline, then raise up the ''good cause'' banner and promulgate rules without following APA procedures. *Council of Southern Mountains, Inc.* v. *Donovan*, 653 F.2d 573, 581 (D.C.Cir. 1981).

By way of example, in *Petry* v. *Block*, the court concluded that the passage of a complex and extraordinary statute concerning changes in administrative reimbursements under the Child Care Food Program that imposed a 60-day deadline for the promulgation of interim rules justified the agency's invocation of the good cause exception. Also, in *Methodist Hospital of Sacramento* v. *Shalala*, 38 F.3d 1225 1236, (D.C. Cir. 1994), the court stated that the agency had good cause to waive notice and comment because Congress imposed a statutory deadline of about 4½ months ''to implement a complete and radical overhaul of the Medicare reimbursement system.'' (Emphasis added). Moreover, ''[o]nce published, the interim rules took up 133 pages in the Federal Register: 55 pages of explanatory text; 37 pages of revised regulations, and 41 pages of new data tables.'' Id.

In the instant case, HCFA had five months to implement a relatively simple provision to require a $50,000 or comparable surety bond from home health agencies. After HCFA added additional bond requirements and capitalization requirements (never requested or contemplated by Congress), the regulation took up 63 pages in the Federal Register: 18 pages of explanatory text, 6 pages of revised regulations, and 39 pages of application documents. The final rule appeared in the Federal Register on January 5, 1998—four days after the mandatory effective date.

The Office of Advocacy opines that if HCFA had not included the additional requirements, which were not intended by Congress, and therefore not intended to be implemented within the five month window, there would have been ample time to follow proper notice and comment procedures. Based on the circumstances of this rulemaking and pointed case law, HCFA cannot rely on the impracticability argument to demonstrate that it had good cause to waive notice and comment.

Second, HCFA also based its good cause exception to notice and comment on the fact that they have the statutory authority to do so with regard to this particular type of rule. The agency states: ''Issuing a proposed rule prior to issuing a final rule is also unnecessary with respect to the Medicare surety bond regulation because the Congress has provided that a Medicare rule need not be issued as a proposed rule before issuing a final rule if, as here, a statute establishes a specific deadline for the implementation of a provision and the deadline is less than 150 days after the enactment of the statute in which the deadline is contained.''[6]

HCFA cannot rely on this statutory provision because the agency has gone way beyond their statutory mandate in issuing this final rule. Again, Congress only intended there to be a $50,000 or comparable surety bond. Therefore, only those provisions contemplated by Congress should be subject to the statute that permits HCFA to waive notice and comment when the deadline is less than 150 days.

Third, HCFA claims that a delay in implementing the final rule would be contrary to public policy. Quite the contrary—implementing the final rule as written would be contrary to public policy. The final rule imposes serious economic burdens on an industry already under increased scrutiny and financial hardship including a recent moratorium on entrants to the Medicare program and repeated audits.[7] HCFA has also announced its intention to include home health agencies in the enormously complicated prospective payment system now used by hospitals and physicians. As such, availability of home healthcare for those communities not served by giant hospital-based providers will surely decrease. This result seems contrary to the stated public policy objective of Congress and HCFA.

Finally, it should be noted that HCFA did insert a post-effective date comment period in the final rule. However, the fact that HCFA attached a comment period to the final rule is not a valid substitute for the normal provisions of the APA. The third circuit stated that: ''[i]f a period for comments, after issuance of a rule, could cure a violation of the APA's requirements, an agency could negate at will the Congressional decision that notice and an opportunity for comment must precede promulgation. Provisions of prior notice and comment allows effective participation in the rulemaking process while the decision maker is still receptive to information and argument. After the final rule is issued, the petitioner must come hat-in-hand and run the risk that the decision maker is likely to resist change.'' *Sharon Steel Corp.* v. *EPA*, 597 F.2d 377, 381 (3rd Cir. 1979).

HCFA's waiver of administrative procedure would be less troubling if the rule were not so burdensome. By waiving notice and comment procedures, the agency conveniently removes itself from the obligation to carefully analyze and solicit input on the impact

of the rule. Such an analysis could have yielded other, less burdensome alternatives that would have accomplished the agency's public policy objectives.

Since HCFA improperly waived notice and comment, the agency must comply with the Regulatory Flexibility Act.

III. REGULATORY FLEXIBILITY ACT REQUIREMENTS

Even when a regulation is statutorily mandated, agencies are obligated by law to adhere to certain requirements prior to issuing the implementing regulations. Specifically, the RFA requires agencies to analyze the impact of proposed regulations on small entities and consider flexible regulatory alternatives that reduce the burden on small entities—without abandoning the agency's regulatory objectives. Agencies may forgo the analysis if they certify (either in the proposed or final rule) that the rule will not have a significant economic impact on a substantial number of small entities. Agency compliance with certain provisions of the RFA is judicially reviewable under section 611 of the RFA.

It is not clear from the instant rule whether HCFA has actually certified the rule pursuant to section 605(b) of the RFA or attempted a final regulatory flexibility analysis (FRFA) pursuant to section 604 of the RFA. In either case, the agency failed to comply with the requirements of the RFA.

HCFA expresses confusing ''certification-like'' statements throughout the text of the final rule.[8] However, the actual certification and statement of factual basis are not to be found in the final rule. If the agency was attempting to certify, then it did so erroneously for reasons discussed more fully below. On the other hand, perhaps HCFA did not intend to certify, but instead intended to prepare a FRFA. The agency did do some type of analysis: ''we have prepared the following analysis, which in conjunction with other material provided in this preamble, constitutes an analysis under the [RFA].'' 63 Fed. Reg. at 303. The problem with that declaration is that there is more than one type of analysis under the RFA. There is the preliminary assessment analysis which helps agencies determine whether to certify, and in the case of a final rule, there is a FRFA when an agency determines that certification is not appropriate. If HCFA was attempting a FRFA, then the FRFA was not adequate because it contained no analysis of alternatives to reduce the burden on small home health care providers. This, too, is more fully discussed below.

A. CERTIFICATION

When an agency determines and certifies that a rule will not have a significant economic impact on a substantial number of small entities, then it is logical to assume that the agency has already performed some basic level of analysis to make that determination. Will a substantial number of small entities be impacted? In the instant case, the agency admits that all home health agencies will be affected. According to SBA's regulations, a small home health care agency is one whose annual receipts do not exceed $5 million, or one which is a not-for-profit organization.[9] Although the Office of Advocacy does not have data based on annual receipts, data is available based on number of employees. 1993 data obtained from the U.S. Bureau of the Census by the Office of Advocacy indicates that about 7% of home health care services (489 out of 6,928) have 500 or more employees and earn 51.2% of all annual receipts for the industry, 93% of home health care services (6,439 out of 6,928) have fewer than 500 employees and earn about 49% of all annual receipts for the industry, and 52.5% of home health care services (3,637 out of 6,928) have fewer than 20 employees and earn 6.3% of all annual receipts for the industry. Although it may be difficult to reconcile employment-based and receipt-based size standards, it is still fairly clear from the available data that a substantial number of small entities will be impacted by this final rule.

Will there be a significant economic impact? To determine whether the final rule is likely to have a significant economic impact, further analysis is required. It is not enough to claim that elimination of fraud and abuse in the Medicare/Medicaid system outweighs the need for further analysis. It is not enough to assume that only those agencies with ''past aberrant billing activities'' will be impacted. It is not enough to say that reducing a surety's liability means that there will not be a significant economic impact on home health agencies. The Office of Advocacy opines that the agency's ''analysis'' was doomed from the outset because of the agency's flawed assumptions about the number and type of small entities likely to be impacted, and about the cost of compliance.

Which small entities will be impacted? The agency did not take the basic and necessary step of adequately explaining why other small entities (presumably those whose billing practices are not ''aberrant'') will not be affected or whether small home health providers are even the primary offenders. At the least, the agency must consider the impact the bonding requirement will have on all small home health providers and not just the ones with ''aberrant'' billing practices. After all, the majority of home health agencies apparently do not have aberrant billing practices. HCFA presents evidence that, in 1996, Medicare overpayments were 7 percent of all claims paid to HHAs, and of that 7 percent, 14 percent remained uncollected by Medicare. Fourteen percent of 7 percent is .0098.[10] In other words, Medicare fails to collect overpayments less than one percent of the time. Despite this extremely low occurrence of failure to collect overpayments, HCFA deemed it necessary to place extremely costly and burdensome requirements on the entire industry. However, HCFA did not identify what percentage of the industry is contributing to the fraud problem, whether certain offenders were recidivist, or whether those offenders are primarily large or small.

With regard to the capitalization requirement, HCFA states that, ''An organization that is earnest in its attempt to be a financially sound provider of home health services under the Medicare program will already be properly capitalized without the need for Medicare to require such capitalization.'' This statement is basically true. However, the issue of adequate capitalization is relative and fungible because it is based on a number of factors like varying overhead costs, location, profit margins, competition in the area, etc. Surely some home health agencies cannot meet the capitalization requirements set by HCFA, but desire to be ''earnest'' in their efforts to be ''sound providers.'' The capitalization requirement is a barrier to market entry for all new home health agencies and not just the ones who enter the market for purposes of defrauding Medicare. A careful look at the questions like the ones raised in this and the preceding paragraph would have yielded a conclusion that the rule would have a significant economic impact on a substantial number of small businesses.

Congress weighed in on the issue of impact after the final rule is published. Even members of Congress recognized that HCFA went beyond its mandate and imposed a significant economic burden on home health agencies. Specifically, a bi-partisan group of three senators from the Senate from the Senate Finance Committee, on January 26, 1998, asked HCFA to delay and modify the requirement that all home health agencies secure a surety bond. The Senators believed that home health agencies would not be able to obtain bonds by the original February 27 deadline. According to a recent news article, the senators reportedly wrote that:

''HCFA has imposed conditions that go beyond the standard in the surety bond industry. Some of the biggest problems include cumulative liability, a short period of time in which to pay claims, and bond values of 15 percent of the previous year's Medicare revenues with no maximum, the letter said.

'The cumulative effect is that many surety companies are opting not to offer bonds to Medicare [home health agencies] at all', the letter said. 'Those companies which are offering the bonds are doing so at a cost which is prohibitive, or with demands for collateral or personal guarantees that HHAs cannot provide.'

The letter said Congress enacted the surety bond requirement to keep risky agencies out of the Medicare program. However, HCFA's rule seems to use the bonds as security for overpayments to providers, the letter said.

'We simply doubt that it is realistic to expect bonding companies to embrace a role as guarantors for overpayments from HCFA,' the senators wrote.''[11]

It should be fairly obvious to HCFA, as it was to these members of Congress, that obtaining a $50,000/15 percent bond in addition to the 3-month reserve capitalization requirement (where there were no such requirements before) is likely to be prohibitively costly for small home health care providers—particularly new providers or providers operation only a few years that typically have few hard assets and relatively little credit.[12] Moreover, most home health patients are Medicare patients. If a home health agency is not Medicare certified, then it is very difficult to attract patients, and without patients, there is no opportunity to increase capital. There is already a requirement in many states (pursuant to ''Operation Restore Trust'') that home health agencies have a minimum number of patients prior to obtaining a Medicare license. How can these small home health agencies absorb losses on these ten patients (—possibly long term patients requiring multiple services several times per week—), never be reimbursed for services to these patients, and continue to raise capital? It's a vicious circle and there is a tremendous cumulative effect of all the various state and federal regulations. In any event, it seems that with only a cursory analysis and a little industry outreach, HCFA should have been able to determine that the final rule would have a significant economic impact on a substantial number of small entities. Therefore, under the RFA, HCFA should have prepared a final regulatory flexibility analysis with all the required elements for that analysis.

B. FINAL REGULATORY FLEXIBILITY ANALYSIS

The preparation of a FRFA may be delayed but not waived. Section 608(b) of the RFA reads: ''Except as provided in section 605(b) [where an agency certifies that there will be no significant economic impact on a substantial number of small entities], an agency head may delay the completion of the requirements of section 604 of this title [regarding the preparation of FRFAs] for a period of not more than one hundred and eighty days after the date of publication in the Federal Register of a final rule by publishing in the Federal Register, not later than such date of publication, a written finding, with reasons therefor, that the final rule is being promulgated in response to an emergency that makes timely compliance with

the provisions of section 604 of this title impracticable. If the agency has not prepared a final regulatory analysis pursuant to section 604 of this title within one hundred and eighty days from the date of publication of the final rule, such rule shall lapse and have no effect. Such rule shall not be repromulgated until a final regulatory flexibility analysis has been completed by the agency.''

FRFAs may not be waived because they serve a vital function in the regulatory process. The preparation of a FRFA allows an agency to carefully tailor its regulations and avoid unnecessary and costly requirements while maintaining important public policy objectives. Without a careful analysis—which should include things like data, public comments and a full description of costs—agencies would be operating in a vacuum without sufficient information to develop suitable alternatives.

Since the agency did not issue a proposed rule, the agency had an obligation to consider carefully all of the significant comments regarding the impact of the final rule. After all, the agency was apparently unsure of the impact.[13] The congressional letter should have been some indication that there would be a significant economic impact and that further analysis was required. HCFA did extend the deadline for obtaining a surety bond for 60 days, and in some ways limited the liability of sureties. However, the agency did not change the bond or capitalization requirements, or explain why such changes were not feasible. Inasmuch as the agency failed to heed any of the comments regarding impact—even those from Congress—the comment period served no real function here.

The dearth of information regarding less costly alternatives is possibly the most serious defect in the analysis presented. To begin with, HCFA never demonstrated why the $50,000 bond was insufficient or would not accomplish the objective of discouraging bad actors from entering the Medicare program. The agency did not demonstrate why the 15 percent rule would not cause a significant economic impact—particularly when the $50,000 bond amount changed from a maximum level to a maximum level. There is no evidence that HCFA attempted to find less costly alternatives. Before heaping on additional regulations, would it not be prudent to first determine whether the programs and policies recently put in place by the Administration, and the prospective payment rules yet to come will work?

IV. CONCLUSION

Not everyone in the home health industry is a bad actor. More importantly, home health providers that cannot afford to comply with HCFA's regulations are not necessarily bad actors either. HCFA has twisted Congress' intent and changed the rule into a vehicle for punishing legitimate home health agencies and for securing overpayments by Medicare rather than a vehicle to discourage bad actors from entering the Medicare program. There must be a middle ground—a place where legitimate home health providers can survive and compete in the marketplace, and where fraud and abuse can be controlled. This final rule is not that place.

Therefore, the Office of Advocacy petitions HCFA to amend its final rule to remove the 15% bonding requirement and the capitalization requirement until such time as proper notice and comment procedures can be completed. Thank you for your prompt attention to this urgent matter. Please contact our office if we may assist you in your efforts to comply with the RFA on this or any other rule effecting small entities, 202–205–6533.

Sincerely,

JERE W. GLOVER,
Chief Council for Advocacy.

SHAWNE CARTER MCGIBBON,
Asst. Chief Counsel for Advocacy.

FOOTNOTES

[1] Regulatory Flexibility Act. 5 U.S.C. §601, as amended by the Small Business Regulatory Enforcement Fairness Act, Pub. L. No. 104–121. 110 Stat. 866 (1996).

[2] *See* 143 CONG. REC. H6253–6254 (daily ed. July 29, 1997).

[3] 143 CONG. REC. S6159 (daily ed. July 24, 1997) (statement of Sen. Hatch).

[4] *Id.* at S6159–60.

[5] Those requirements include basing the amount of the bond on a flat rate in combination with the $50,000 minimum bond. The flat rate is designated as 15 percent of the annual amount paid to the HHA by Medicare as reflected in the HHA's most recently accepted cost report. The other major requirement for new the HHAs is for minimum capitalization. The amount of the reserve is to be determined by Medicare intermediaries based on the first year experience of other HHAs. First the intermediary determines an average cost per visit based on first-year cost report data for at least three HHAs that it serves that are comparable to the HHA seeking to enter the Medicare program. The average cost per visit is determined by dividing the sum of the total reported costs of care for all patients of the HHAs by the sum of their total visits. Then, the intermediary multiplies the average cost per visit by the projected number of visits for all patients (Medicare. Medicaid and all other patients) for the first three months of operation of the HHA asking to inter the program. HCFA also designates which funds count toward satisfying the capitalization requirement (—fifty percent of the funds required for capitalization must be non-borrowed funds) Medicare expects those funds to be available in cash or, in some cases short term highly liquid cash equivalents.

[6] 63 Fed. Reg. at 308.

[7] In September 1997. President Clinton announced that the Department of Health and Human Services was declaring the first ever moratorium to stop new home health providers from entering the Medicare program. The moratorium was lifted in January after the instant final rules were published in the Federal Register. The Office of Advocacy received at least one call form an anxious home health agency just starting their business. The agency had completed the reams of paperwork and all the other necessary requirements for entering the Medicare program, but had to put everything on hold because of the 4-month moratorium—announced just days before their Medicare application would have been approved. Where is this business going to get three months reserve to demonstrate that their business is adequately capitalized? Unable to enter the Medicare program, how have they survived thus far (when you consider that 95% of home health patients are Medicare eligible)?

Another business contacted the Office of Advocacy to complain that their home health agency had been audited three times in one year under the Administration's ''Operation Restore Trust.''

[8] Some of those statements include the following: ''Because of the scope of the rule, all HHAs will be affected, but we do not expect that effect to be significant.'' 63 Fed. Reg. at 303. ''We expect to have a 'significant impact' on an unknown number of such entities, effectively preventing some from repeating their past aberrant billing activities [but, t]he majority of HHAs will not be significantly affected by this rule.'' *Id.* ''[A]ny possible impact that this [capitalization] requirement may have on HHAs entering the Medicare program is more than offset by savings to the Trust Funds in situations in which HHAs go out of business due to undercapitalization . . .'' *Id.* at 308. ''We are not preparing a rural impact statement [pursuant to section 1102(b) of the Social Security Act] since we have determined, and certify, that this rule would not have a significant impact on the operations of a substantial number of small rural hospitals.'' *Id.* ''If a new HHA for some reason cannot raise the capital necessary to meet Medicare's [capitalization] requirement and, therefore, is not permitted to enter the Medicare program, that clearly has an impact on the HHA.'' *Id.*

[9] *See* 13 C.F.R. §121.201. Based on Standard Industrial Classification code 8082. Home Health Care Services include home health care agencies and visiting nurse associations (establishments primarily engaged in providing skilled nursing or medical care in the home, under supervision of a physician. Establishments of registered or practical nurses engaged in the independent practice of their professions and nurses' registries and classified in another category. Similarly, establishments primarily engaged in selling, renting or leasing health care products for personal or household use are classified in another category).

[10] In 1996. $14,357,504,894 was paid to HHAs, $1,061,157,961 was overpaid, and $153,628,056 was uncollected.

[11] *Senators Ask HCFA to Delay Final Rule Requiring Surety Bonds of All Agencies.* BNA DAILY REPORT FOR EXECUTIVES. Jan 27, 1998, at A–24.

[12] Small firms in service industries find it more difficult to obtain credit—where judgments in terms of character, markets, and cash flow are more likely to dominate—than in manufacturing industries, which typically have hard assets such as real property, equipment, and inventory. OFFICE OF ADVOCACY, U.S. SMALL BUSINESS ADMINISTRATION. THE STATE OF SMALL BUSINESS: A REPORT OF THE PRESIDENT (1995) at 86.

[13] Unsure of the actual impact, the agency specifically solicited comments on its assertions and assumptions. *See* 63 Fed. Reg. at 304.

Mr. BAUCUS. Mr. President, I would like to say a few words about the Bond-Baucus-Grassley Joint Resolution introduced today that nullifies a regulation which threatens to put many of my state's home health agencies, or HHAs, out of business. Our resolution officially disapproves the regulation issued by the Health Care Financing Administration on June 1 of this year. The rule requires each home health agency that receives Medicare reimbursement to buy a costly surety bond. This expensive bond is out of reach for many of the agencies that provide in-home service to Montana's elderly and low income residents.

Let me say from the outset that I support the provision in the Balanced Budget Act of 1997 requiring HHAs to post a surety bond for Medicare and Medicaid. Perhaps we need to make some changes to the statute, but the underlying idea—to protect the Medicare program by requiring home health agencies to post a bond—is a good one. Unfortunately, the regulation HCFA plans to implement requires a much higher bond amount.

One Montana home health agency based in Butte would have to post a bond of more than $600,000 under the HCFA regulation. That's an outrage. And it will put that company, and many others across the country, out of business.

I am also concerned that HCFA has incorrectly interpreted Congressional intent by using the bonds to collect on Medicare overpayments, not just fraud. As a result, many HHA owners are being asked to put up personal assets, such as their house, as collateral for the bond. These agencies tend to be non-hospital based and not tied to a larger corporate structure. All have far less than $600,000 in personal and business assets. We shouldn't expect anyone to sign over those assets just to do business in the Medicare program.

Also, many HHAs are family-owned small businesses. We cannot let any federal regulation force small businesses to close their door. This not only affects businesses, but also their customers—our bed-ridden elderly.

That is why we have acted here today. The Bond-Baucus-Grassley resolution will invoke the Congressional