DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Chapter IV

[CMS–6012–N3]

RIN 0938–AL13

Medicare Program; Negotiated Rulemaking Committee on Special Payment Provisions and Requirements for Prosthetics and Certain Custom-Fabricated Orthotics; Meeting Announcement

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Notice of meetings.

SUMMARY: In accordance with section 10(a) of the Federal Advisory Committee Act, this document announces additional public meetings of the Negotiated Rulemaking Committee on Special Payment Provisions and Requirements for Prosthetics and Certain Custom-Fabricated Orthotics. The Committee was mandated by section 427 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA).

DATES: The next two negotiated rulemaking committee meetings will be held January 6 and 7, 2003; and February 10 and 11, 2003 from 9 a.m. to 5 p.m. e.s.t.

These meetings are open to the public, and subsequent meetings will be announced in the **Federal Register**.

ADDRESSES: The Committee meetings will be held at the Hilton Pikesville at 1726 Reisterstown Road, Baltimore, MD 21208, (Telephone 410–653–1100). Any subsequent meetings will be held at locations to be announced.

FOR FURTHER INFORMATION CONTACT:

Theresa Linkowich, (410) 786–9249 (General inquiries concerning prosthetics and custom-fabricated orthotics), Centers for Medicare & Medicaid Services (CMS), 7500 Security Blvd, Baltimore MD 21244; or

Lynn Sylvester, 202–606–9140, Federal Mediation and Conciliation Services, 2100 K Street, NW., Washington, DC 20427; or

Ira Lobel, 518–431–0130, Federal Mediation and Conciliation Services, 1 Clinton Square, Room 952, Albany, NY 12207.

SUPPLEMENTARY INFORMATION: We published a document in the **Federal Register** on July 26, 2002 (67 FR 48839), announcing the establishment of the negotiated rulemaking committee to advise us on developing a proposed rule that would establish special payment provisions and requirements for suppliers of prosthetics and certain custom-fabricated orthotics under the Medicare program. The document also announced dates for the Committee's first two meetings on October 1 to 3, 2002, and October 29 to 31, 2002.

Through face-to-face negotiations, these meetings will help the Committee to reach consensus on the substance of the proposed rule. If consensus is reached, the Committee will transmit to us a report containing required information for developing a proposed rule, and we will use the report as the basis for the proposed rule. The Committee is responsible for identifying the key issues, gauging their importance, analyzing the information necessary to resolve the issues, arriving at a consensus, and recommending the text and content of the proposed regulation. Detailed information is available on the CMS Internet Home Page: *http://cms.hhs.gov/faca/prosthetic/* or by calling the Federal Advisory Committee Hotline at (410) 786–9379.

The agendas for the January 5 and 6, 2002 and February 10 and 11, 2002 meetings will cover the following:

1. Review of the October 29 to 31 minutes (January 5 and 6) and review of the January 5 and 6 minutes (February 10 and 11).
2. Workgroup presentations on orthotics and prosthetics.
3. Consensus on workgroup items.
4. Development of new workgroups (as applicable).
5. Presentation by the American Society of Hand Therapists (January 5 and 6).
6. Public comment period.

Public Participation

All interested parties are invited to attend these public meetings, but attendance is limited to the space available. No advance registration is required. Seating will be available on a first-come first'served basis. Individuals requiring sign language interpretation for the hearing impaired or other special accommodations should contact Theresa Linkowich, at e-mail address *tlinkowich@cms.hhs.gov,* or call (410) 786–9249 at least 10 days before the meeting. The Committee has the authority to decide to what extent oral presentations by members of the public may be permitted at the meeting. Oral presentations will be limited to statements of fact and views, and shall not include any questioning of the Committee members or other participants unless the facilitators have specifically approved these questions. The number of oral presentations may be limited by the time available.

Interested parties can file statements with the Committee. Mail written statements to the following address: Federal Mediation and Conciliation Services, 2100 K Street, NW., Washington, DC 20427, Attention: Lynn Sylvester, or call Lynn Sylvester at (202) 606–9140.

Additional Meetings

Meetings will be held as necessary. We will publish notices of future meetings in the **Federal Register**. All future meetings will be open to the public without advance registration.

Authority: Federal Advisory Committee Act (5 U.S.C. App. 2)

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

Dated: November 19, 2002.

Thomas A. Scully,

Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 02–29795 Filed 11–21–02; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 412, 413, 476, and 484

[CMS–3055–P]

RIN 0938–AK68

Medicare Program; Photocopying Reimbursement Methodology

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Proposed rule.

SUMMARY: This proposed rule would increase the rate of reimbursement for expenses incurred by prospective payment system (PPS) hospitals for photocopying medical records requested by Quality Improvement Organizations (QIOs), formerly known as Utilization and Quality Control Peer Review Organizations (PROs). We would increase the rate from 7 cents per page to 12 cents per page, in accordance with the formula for calculating this rate to reflect inflationary changes in the labor and supply cost components of the formula.

This proposed rule would also provide for the periodic review and adjustment of the per-page reimbursement rate to account for

inflation and changes in technology. The methodology for calculating the per-page reimbursement rate would remain unchanged.

We also propose to provide for the payment of the expenses of furnishing photocopies to QIOs, to other providers subject to a PPS (for example, skilled nursing facilities and home health agencies), in accordance with the rules established for reimbursing PPS hospitals for these expenses.

DATES: We will consider comments if we receive them at the appropriate address, as provided below, no later than 5 p.m. on January 21, 2003.

ADDRESSES: In commenting, please refer to file code CMS–3055–P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission. Mail written comments (one original and three copies) to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–3055–P, PO Box 8010, Baltimore, MD 21244–8010.

Please allow sufficient time for mailed comments to be timely received in the event of delivery delays.

If you prefer, you may deliver (by hand or courier) your written comments (one original and three copies) to one of the following addresses: Room 443–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201, or Room C5–14–03, 7500 Security Boulevard, Baltimore, MD 21244–1850.

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and could be considered late.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT: Valerie Mattison Brown, (410) 786–5958.

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, please call (410) 786–9994.

Copies: To order copies of the **Federal Register** containing this document, send your request to: New Orders, Superintendent of Documents, P.O. Box 371954, Pittsburgh, PA 15250–7954. Specify the date of the issue requested and enclose a check or money order payable to the Superintendent of Documents, or enclose your Visa or Master Card number and expiration date. Credit card orders can also be placed by calling the order desk at (202) 512–1800 (or toll-free at 1–888–293–6498) or by faxing to (202) 512–2250. The cost for each copy is $9. As an alternative, you can view and photocopy the **Federal Register** document at most libraries designated as Federal Depository Libraries and at many other public and academic libraries throughout the country that receive the **Federal Register**.

This **Federal Register** document is also available from the **Federal Register** online database through *GPO Access,* a service of the U.S. Government Printing Office. The web site address is: *http://www.access.gpo.gov/nara/index.html.*

I. Background

Section 1866(a)(1)(F) of the Social Security Act (the Act) requires a hospital, as a condition of Medicare participation, to enter into an agreement with a quality improvement organization (QIO), for the peer review of Medicare services provided by the hospital. (**Note:** QIOs were formerly known as peer review organizations (PROs). We published a final rule with comment period on May 24, 2002 (67 FR 36539) changing the name to QIOs.) Our regulations at 42 CFR 476.78 provide that health care facilities that submit Medicare claims must cooperate in the conduct of QIO reviews, including providing the QIO with information necessary to its determinations. This often includes providing the QIO with photocopies of patients' medical records.

We published a final rule on October 20, 1992 in the **Federal Register** (57 FR 47779), following notice-and-comment rulemaking, which established a formula for calculating the rate of reimbursement for these photocopy costs incurred by hospitals. Using this formula, we set the rate at 7 cents per-page. The regulation requires us to determine a fixed payment amount per page by adding per-page labor costs and per-page supply costs. The regulation also provides for Medicare payment for the costs of first class postage for mailing records to QIOs. As discussed in detail in the October 20, 1992 final rule (57 FR 47779), the payment established by § 476.78 represents an additional payment to hospitals under the prospective payment system (PPS) for photocopy costs. Payment for the equipment and overhead costs associated with furnishing the QIO with required documentation is made under other Medicare payment provisions for capital-related costs and inpatient operating costs.

The formula for calculating the per-page reimbursement rate for photocopies is set forth at § 476.78(c), which provides:

Photocopying reimbursement methodology for prospective payment system hospitals. Hospitals subject to the prospective payment system are paid for the photocopying costs that are directly attributable to the hospitals' responsibility to the QIOs to provide photocopies of requested hospital records. The payment is in addition to payment already provided for these costs under other provisions of the Social Security Act and is based on a fixed amount per page as determined by CMS as follows:

(1) *Step one.* CMS adds the annual salary of a photocopy machine operator and the costs of fringe benefits as determined in accordance with the principles set forth in OMB circular A–76.

(2) *Step two.* CMS divides the amount determined in paragraph (c)(1) of this section by the number of pages that can be reasonably expected to be made annually by the photocopy machine operator to establish the labor cost per page.

(3) CMS adds to the per-page labor cost determined in paragraph (c)(2) of this section the per-page costs of supplies.

Using this formula we established the per-page rate of 7 cents in the October 20, 1992 final rule. The validity of this rule and its reimbursement methodology were challenged in a certified class action by Medicare-participating hospitals, in the U.S. Court of Appeals for the Ninth Circuit. *Queen of Angels/ Hollywood Presbyterian Medical Center* v. *Shalala,* 65 F.3d 1472, 1476 (9th Cir. 1995). The Court of Appeals upheld the validity of our photocopy reimbursement methodology and sustained the lawfulness of the 7 cents per page rate established in the rule.

Due to increases in labor and supply costs, we are proposing to increase the reimbursement rate from 7 cents per page to 12 cents per page in accordance with the established court-approved methodology set forth in § 476.78(c).

Current Photocopy Reimbursement Rate

Under the current regulation, we apply a uniform per-page rate on a nationwide basis to all PPS hospitals that have QIO agreements. We base the calculation on labor and supply costs. The calculation in the current rule, as discussed in the preamble to the October 20, 1992 rule, is based on the following:

- An operator will copy approximately 364,320 pages annually.

• The salary level of an operator is equivalent to a GS–5 experienced midlevel secretary ($17,686) plus 27.9 percent fringe benefits ($4,934) for a total salary of $22,620.

• Paper costs are 0.5 cents per page ($25 per case of paper with 5,000 sheets in a case).

• Toner and developer costs are 0.5 cents per page.

• The total cost per page is 7 cents.

II. Provisions of the Proposed Regulations

We propose to increase the rate of QIO-related photocopy reimbursement from 7 cents to 12 cents per page. We calculated this rate by updating the salary, fringe benefits, and supply figures used in the October 20, 1992 final rule. In accordance with the methodology at § 476.78(c), we considered the following factors in calculating the proposed rate: (1) The labor costs associated with photocopying and (2) the costs of supplies.

A. Labor Costs

Labor costs were calculated consistent with the methodology at § 476.78(c), first, by adding the annual salary of a photocopy machine operator with the costs of fringe benefits, and second, by dividing that sum by the number of pages that can reasonably be expected to be made in a year.

B. Annual Salary of a Photocopy Machine Operator

In the October 20, 1992 rule, we adopted the salary level for an experienced (GS–5) midlevel secretary in the Federal government as representative of that of a photocopy machine operator. Use of this figure approximated or exceeded the actual salary information for individuals performing these tasks that had been submitted by various commenters. Furthermore, we determined that use of this salary level yielded payments that were more than adequate to ensure a sufficient skill level. The annual salary of $17,686 used in the October 20, 1992 rule was derived from the U.S. Office of Personnel Management's 1992 General Schedule.

In this proposed rule, we would continue to deem the salary of a Federal GS–5 midlevel secretary as representative of a photocopy operator's salary; however, we would update the figure to take into account increases in the payment rate of a midlevel secretary. Thus, we are using the GS–5 annual salary of $28,727 derived from the U.S. Office of Personnel Management's 2002 General Schedule to calculate the revised rate.

C. Fringe Benefits

In the October 20, 1992 final rule, we ascribed the fringe benefits of an employee to be 27.9 percent of the employee's salary, which was the standard percentage dictated by the cost principles set forth in the Office of Management and Budget (OMB) Circular A–76. While there may be other yardsticks to measure this component of costs, we find this to be a reasonable resource since the thrust of this OMB circular is to help the government compare potentially incurred costs to determine whether the costs can be more economically incurred internally or through contract with a commercial source. Therefore, we continue to use OMB Circular A–76 to calculate the annual fringe benefit cost. Accordingly, fringe benefits were calculated in this proposed rule based on 29.7 percent of the GS–5 salary as outlined in the OMB Circular A–76 Transmittal Memorandum 19—FY 2000 estimate. Thus, the annual fringe benefit cost is $8,532 ($28,727 * 29.7 percent).

D. Number of Pages Copied Annually

In this proposed rule, we are using 364,320 pages per year in the calculation of the annual labor cost. In the October 20, 1992 rule, we determined that 364,320 was the number of pages that could reasonably be expected to be copied in a year. Earlier, in the proposed rule ''Changes to Peer Review Organizations Regulations'', published on March 16, 1988 at 53 FR 8654, we had proposed the use of 748,000 pages per year in the calculation of the annual labor cost. This initial figure was determined based on copying documents at a rate of six pages per minute for each hour in an 8 hour day, 5 days a week, 52 weeks per year. The estimate was based on hand feeding of documents into the photocopying machine for duplication, although we recognized that there are many photocopying tasks that may be accomplished through automatic feeds. Automatic feeds greatly increase the number of pages that can be generated by a machine on an hourly basis, and as a result, greatly decrease the cost of photocopying per page.

In response to comments received on the March 16, 1988 proposed rule (53 FR 8654), we revised the 748,000 figure in the October 20, 1992 final rule to account for time spent by the photocopy machine operator in search and retrieval tasks, and time away from work on annual vacation, sick, and holiday leave. This resulted in a reduction from 748,000 to 364,320 in our estimate of the number of pages that may be reasonably expected to be made annually, and a corresponding increase in the per-page labor rate.

We are unaware of any significant changes in technology since the October 20, 1992 final rule (57 FR 47779) that would lead to either a significant decrease or increase in the annual number of pages that may be copied. Nor are we aware of any changes that would significantly increase or decrease the time allocated to search and retrieval tasks. Therefore, we continue to use the 364,320 figure to calculate the per-page labor cost in this proposed rule.

E. Calculation of Per-Page Labor Costs

To determine the per-page labor cost, the total of salary ($28,727) and fringe benefits ($8,532) costs, which amount to $37,259, was divided by 364,320 pages, the number of copies made in a year, resulting in an annual labor cost per page of 10 cents ($37,259/364,320 pages).

F. Supply Costs

In the October 20, 1992 final rule, supply costs were calculated based on 0.5 cents per page for paper and 0.5 cents per page for toner and developer. The paper cost was based on a cost of $25 per case of paper with 5,000 sheets in a case. The costs of toner and developer vary widely depending on the type of photocopy machine used. However, based on comments from hospitals and a large hospital association, it was determined at that time that a reasonable amount for toner and developer was 0.5 cents per page.

The total proposed supply cost is 2.3 cents per page. This is based on a per-page paper cost of 0.5 cents and a developer and toner cartridge cost of 1.8 cents per page. The paper costs were calculated based on $23 per case of paper with 5,000 sheets in a case. This equates to 0.5 cents per page ($23/5,000).

As previously stated, in the October 20, 1992 rule the toner and developer costs of 0.5 cents per page were determined on the basis of comments received on the proposed rule. In this rule, we have used an objective methodology to calculate the per-page cost for toner and developer that can also be used in future updates. We calculated these costs using estimates of the costs for toner cartridges and developer drums contained in the GSA supply catalogue, and on the basis of a photocopy machine producing 364,320 pages annually.

G. Payment Rate Per Page

Consistent with § 476.78(c)(3), the payment rate per page is the total of the per-page labor cost and the per-page supply cost, which is equivalent to 12 cents. The established calculation methodology actually results in a cost of 12.3 cents per page, however, consistent with CMS policy and generally accepted mathematics principles, we chose to round down to 12 cents. We believe this decision is both reasonable and supportable, based on the fact that the higher amount substantially exceeds all published OMB inflation indexes, including the CPI-Wage index (photocopying expense is largely comprised of labor costs).

H. Future Updates to Rate of Photocopy Reimbursement

In addition to updating the rate of reimbursement for photocopies, we also propose to amend the existing regulation to permit the rate to be adjusted without undergoing notice-and-comment rulemaking each time it needs to be adjusted to reflect inflationary or technology changes.

We intend to review and adjust the rate periodically in accordance with the same factors considered in establishing the rate in the October 20, 1992 final rule and the updated rate in this proposed rule. This review will include an examination of the labor and supply components of the formula, and we will update the rate as necessary to account for significant inflationary changes to these components.

Absent some compelling reason, in future updates, we will continue to deem the salary and fringe benefits of a Federal government GS–5 midlevel secretary as representative of the salary and fringe benefits of a photocopy machine operator and use those values to calculate the reimbursement rate. Also, absent some compelling reason or major technological change that would lead to a significant increase or decrease in the number of pages that can be made annually, we will not change the number of pages used in calculating the rate.

I. Reimbursement to Other PPS Providers of the Cost of Photocopying

We also propose to provide for the payment of the expenses of furnishing photocopies to QIOs, to other providers subject to a PPS (for example, skilled nursing facilities (SNFs) and home health agencies (HHAs)), in accordance with the rules established at § 476.78 for reimbursing PPS hospitals for these expenses.

Current regulations do not address reimbursement for providers other than hospitals for costs of photocopying medical records in cooperation with QIO review activities because in the past QIO review of providers other than hospitals was relatively insignificant. To the extent that this review activity took place, it was minimal, and the related costs were included on the provider's cost report. SNFs, HHAs, and other providers have recently converted from the cost-based reimbursement system to a PPS. Because QIO review of these providers has been minimal or nonexistent, costs related to this activity are not adequately reflected in the base PPS rate. Therefore, we believe it is appropriate to provide for a means of paying for these costs when they occur. To accomplish this change, we propose to replace the more narrow term ''hospitals'' with ''providers,'' in § 476.78(b)(2) and (c), to include other providers subject to a PPS.

Additionally, we propose revising the payment provisions for SNFs and HHAs by adding a paragraph at § 413.355 and § 484.265, that authorizes reimbursement for the costs of photocopying and mailing medical records required for QIO review, to SNFs and HHAs.

We also propose amending § 476.78(d) to provide that, as with other disputes regarding Medicare payment to providers, disputes concerning payments for costs related to QIO review under § 476.78 and the other payment provisions of the Medicare statute and regulations must be presented in accordance with the administrative and judicial review requirements of section 1878 of the Act and subpart R of 42 CFR part 405.

III. Collection of Information Requirements

Under the Paperwork Reduction Act (PRA) of 1995, agencies are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved, section 3506(c)(2)(A) of the PRA of 1995 requires that we solicit comment on the following issues:

- Whether the information collection is necessary and useful to carry out the proper functions of the agency;
- The accuracy of the agency's estimate of the information collection burden;
- The quality, utility, and clarity of the information to be collected; and
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

Section 476.78 of this regulation contains information collection requirements. In summary, § 476.78 requires providers to submit information to the QIO during the conduct of a QIO review. Because this information is collected during the conduct of an audit, investigation, and/or an administrative action, we believe these collection requirements are not subject to the PRA as stipulated under 5 CFR 1320.4.

If you have any comments on any of these information collection and record keeping requirements, please mail the original and 3 copies directly to the following:

Centers for Medicare and Medicaid Services, Office of Information Services, Standards and Security Group, Division of CMS Enterprise Standards,
Room N2–14–26, 7500 Security Boulevard, Baltimore, MD 21244–1850. Attn: John Burke CMS–3055–P; and
Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503, Attn: Allison Eydt, CMS Desk Officer, CMS–3055–P.

IV. Response to Comments

Because of the large number of items of correspondence we normally receive on **Federal Register** documents published for comment, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and, if we proceed with a subsequent document, we will respond to the major comments in the preamble to that document.

V. Regulatory Impact Statement

We have examined the impacts of this proposed rule as required by Executive Orders 12866 (September 1993, Regulatory Planning and Review) and the Regulatory Flexibility Act (RFA) (September 19, 1980 Pub. L. 96–354).

Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for rules that constitute significant regulatory action, including rules that have an economic effect of $100 million

or more annually. This proposed rule is not a major rule in terms of the aggregate costs involved.

The 53 separate QIO contracts are awarded on a staggered 3-year basis. Current sixth scope of work contracts provide photocopy reimbursement costs of 7 cents per page. The total dollars budgeted were $8.6 million per year and the 3-year costs were $25.9 million. We estimate by the time this regulation is published in final, 19 QIOs will have completed their 6th round contracts and the other 34 will have less than 153 months (combined) out of a total of 636 months (for all 53 QIOs) remaining in the final year of their 6th round contracts. This translates to 24 percent of the final 6th round year. As such, we project this regulation will increase the costs in the last (*i.e.*, current) year of the 6th scope of work by $1.5 million above the previous budgeted level of $8.6 million, to a total of $10.1 million. However, in future years—based on the full 12 months and all 53 QIOs under contract—the increase will be nearly $6.2 million annually.

Thus, we have determined that this proposed rule is not a major rule with economically significant effects because it would not result in increases in total expenditures of $100 million or more per year. We have also determined that it does not otherwise constitute significant regulatory action.

The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and governmental agencies. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of $5 million to $25 million or less annually (see 65 FR 69432). Individuals and States are not included in the definition of a small entity.

We generally prepare a regulatory flexibility analysis that is consistent with the RFA unless we certify that a rule will not have a significant impact on a substantial number of small entities. We have not prepared an analysis for the RFA because we have determined, and certify, that this proposed rule would have no significant economic impact on small entities. The proposed regulation would not impose any economic or operational regulatory burdens on small entities. The regulation would only assist providers in performing the tasks required under the QIO program sixth scope of work, by increasing the reimbursement for providing copies of documents to the QIOs.

Section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 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 100 beds. We have not prepared an analysis for section 1102(b) of the Act because we have determined that this proposed regulation would not have a significant impact on the operations of small rural hospitals for the reasons stated above in our discussion of the RFA.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies prepare an assessment of anticipated costs and benefits before issuing any rule that may result in an expenditure in any 1 year by State, local, or tribal governments, in the aggregate, or by the private sector, of $110 million or more. We have determined that this proposed rule would not result in such an expenditure. Rather, the proposed rule would benefit providers by increasing the photocopy reimbursement rate.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a rule that imposes substantial direct compliance costs on State and local governments, preempts State law, or otherwise has Federalism implications. We have reviewed this proposed rule under the threshold criteria of Executive Order 13132 and have determined that it would not have a substantial direct effect on the rights, roles, and responsibilities of States or local governments.

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

List of Subjects

42 CFR Part 412

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

42 CFR Part 413

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

42 CFR Part 476

Grant programs—health, Health care, Health facilities, Health professions, Quality Improvement Organizations (QIO), reporting and recordkeeping requirements.

42 CFR Part 484

Health facilities, Health professions, Medicare, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services proposes to amend 42 CFR chapter IV to read as follows:

PART 412—PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES

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

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

2. In § 412.115, revise paragraph (c) to read as follows:

§ 412.115 Additional payments.

* * * * *

(c) *QIO photocopy and mailing costs.* An additional payment is made to a hospital in accordance with § 476.78 of this chapter for the costs of photocopying and mailing medical records requested by a QIO.

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), 1871, 1881, 1883, and 1886 of the Social Security Act (42 U.S.C. 1302, 1395d(d), 1395f(b), 1395l(a), (i), and (n), 1395hh, 1395rr, 1395tt, and 1395ww).

2. Add a new § 413.355 to read as follows:

§ 413.355 Additional payment: QIO photocopy and mailing costs.

An additional payment is made to a skilled nursing facility in accordance with § 476.78 of this chapter for the costs of photocopying and mailing medical records requested by a QIO.

PART 476—UTILIZATION AND QUALITY CONTROL REVIEW

1. The authority citation for part 476 continues to read as follows:

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

2. In § 476.78, revise the introductory text to paragraph (b); revise paragraphs (b)(2), (b)(4), and the introductory text to paragraph (c); add new paragraph (c)(4);

and revise paragraph (d) to read as follows:

§ 476.78 Responsibilities of health care providers.

* * * * *

(b) *Cooperation with QIOs.* Health care providers that submit Medicare claims must cooperate in the assumption and conduct of QIO review. Providers must—

* * * * *

(2) Provide patient care data and other pertinent data to the QIO at the time the QIO is collecting review information that is required for the QIO to make its determinations. The provider must photocopy and deliver to the QIO all required information within 30 days of a request. QIOs pay providers paid under the prospective payment system for the costs of photocopying records requested by the QIO in accordance with the payment rate determined under the methodology described in paragraph (c) of this section and for first class postage for mailing the records to the QIO. When the QIO does postadmission, preprocedure review, the facility must provide the necessary information before the procedure is performed, unless it must be performed on an emergency basis.

* * * * *

(4) When the provider has issued a written determination in accordance with § 412.42(c)(3) of this chapter that a beneficiary no longer requires inpatient hospital care, it must submit a copy of its determination to the QIO within 3 working days.

* * * * *

(c) *Photocopying reimbursement methodology for prospective payment system providers.* Providers subject to the prospective payment system are paid for the photocopying costs that are directly attributable to the providers' responsibility to the QIOs to provide photocopies of requested provider records. The payment is in addition to payment already provided for these costs under other provisions of the Social Security Act and is based on a fixed amount per page as determined by CMS as follows:

* * * * *

(4) CMS will periodically review the photocopy reimbursement rate to ensure that it still accurately reflects provider costs. CMS will publish any changes to the rate in a Federal Register notice.

(d) *Appeals.* Reimbursement for the costs of photocopying and mailing records for QIO review is an additional payment to providers under the prospective payment system, as specified in §§ 412.115, 413.355, and 484.265 of this chapter. Thus, appeals concerning these costs are subject to the review process specified in part 405, subpart R of this chapter.

PART 484—HOME HEALTH SERVICES

1. The authority citation for part 484 continues to read as follows:

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

2. Add a new § 484.265 to read as follows:

§ 484.265 Additional payment.

An additional payment is made to a home health agency in accordance with § 476.78 of this chapter for the costs of photocopying and mailing medical records requested by a QIO.

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

Dated: March 27, 2002.

Thomas A. Scully,

Administrator, Center for Medicare & Medicaid Services.

Approved: August 8, 2002.

Tommy G. Thompson,

Secretary.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 418

[CMS–1022–P]

RIN 0938–AJ36

Medicare Program; Hospice Care Amendments

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Proposed rule.

SUMMARY: This proposed rule would revise existing regulations that govern coverage and payment for hospice care under the Medicare program. These revisions are required by the Balanced Budget Act of 1997 (BBA), the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA), and the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA).

The BBA made changes to the time frame for completion of a physician's certification for admission of a patient; the duration of benefit periods; the requirement that hospices make certain services available on a 24-hour basis; the required core services; the coverage of services specified in a patient's plan of care; and the payment of claims according to area. The BBA also established hospice payment rates for Federal fiscal years 1998 through 2002. BBRA amended those rates. BIPA further amended those rates and clarified the physician certification rule.

This rule would also add to existing regulations certain established Medicare hospice policies that currently are available only in policy memoranda. These policies clarify the regulations regarding the content of the certification of terminal illness and the admission to, and discharge from, a hospice.

This rule does not address the requirement for hospice data collection, the changes to the limitation of liability rules, or the changes to the hospice conditions of participation that were included in the BBA.

DATES: Comments will be considered if we receive them at the appropriate address, as provided below, no later than 5 p.m. on January 21, 2003.

ADDRESSES: In commenting, please refer to file code CMS–1022–P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission. Mail written comments (one original and three copies) to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1022–P, Box 8010, Baltimore, MD 21244–8010.

Please allow sufficient time for mailed comments to be timely received in the event of delivery delays.

If you prefer, you may deliver (by hand or courier) your written comments (one original and three copies) to one of the following addresses:

Hubert H. Humphrey Building, Room 443–G, 200 Independence Avenue, SW., Washington, DC 20201, or

Room C5–14–03, 7500 Security Boulevard, Baltimore, Maryland 21244–1850.

(Because access to the interior of the HHH Building is not readily available to persons without Federal Government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for commenters wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

Comments mailed to the addresses indicated as appropriate for hand or