ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 62

[NH–51–7175b; FRL–7447–5]

Approval and Promulgation of State Plans for Designated Facilities and Pollutants: New Hampshire; Plan for Controlling MWC Emissions From Existing Municipal Waste Combustors

AGENCY: Environmental Protection Agency (EPA).

ACTION: Proposed rule.

SUMMARY: The Environmental Protection Agency (EPA) proposes to approve the sections 111(d)/129 State Plan submitted by the New Hampshire Department of Environmental Services (DES) on August 12, 2002. This State Plan is for carrying out and enforcing provisions that are at least as protective as the Emissions Guidelines (EG) applicable to certain existing large and small Municipal Waste Combustion (MWC) units in accordance with sections 111 and 129 of the Clean Air Act. The New Hampshire DES submitted the Plan to satisfy certain Federal Clean Air Act requirements. In the Final Rules section of the **Federal Register**, EPA is approving the New Hampshire State Plan submittal as a direct final rule without a prior proposal. EPA is doing this because the Agency views this action as a noncontroversial submittal and anticipates that it will not receive any significant, material, and adverse comments. A detailed rationale for the approval is set forth in the direct final rule and incorporated by reference herein. If EPA does not receive any significant, material, and adverse comments to this proposed rule, then the approval will become final without further proceedings. If EPA receives adverse comments, the direct final rule will be withdrawn and EPA will address all public comments received in a subsequent final rule based on this proposed rule. EPA will not begin a second comment period.

DATES: EPA must receive comments on this proposed rule in writing by March 12, 2003.

ADDRESSES: You should address your written comments to: Mr. Steven Rapp, Chief, Air Permits, Toxics & Indoor Programs Unit, Office of Ecosystem Protection, U.S. EPA, One Congress Street, Suite 1100 (CAP), Boston, Massachusetts 02114–2023.

Copies of documents relating to this proposed rule are available for public inspection during normal business hours at the following locations. The interested persons wanting to examine these documents should make an appointment with the appropriate office at least 24 hours before the day of the visit.

Environmental Protection Agency, Air Permits, Toxics & Indoor Programs Unit, Office of Ecosystem Protection, Suite 1100 (CAP), One Congress Street, Boston, Massachusetts 02114–2023.

New Hampshire Department of Environmental Services, Air Resources Division, 6 Hazen Drive, P.O. Box 95, Concord, New Hampshire 03301–0095, (603) 271–1370.

FOR FURTHER INFORMATION CONTACT: John Courcier, Office of Ecosystem Protection (CAP), EPA-New England, Region 1, Boston, Massachusetts 02203, (617) 918–1659, or by e-mail at *courcier.john@epa.gov*. While the public may forward questions to EPA via e-mail, it must submit comments on this proposed rule according to the procedures outlined above.

SUPPLEMENTARY INFORMATION: See the information provided in the Direct Final action of the same title which is found in the Rules section of this **Federal Register**.

Dated: January 23, 2003.

Robert W. Varney,

Regional Administrator, EPA New England.

[FR Doc. 03–2940 Filed 2–7–03; 8:45 am]

BILLING CODE 6560–50–U

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 413

[CMS–1126–P]

RIN 0938–AK02

Medicare Program; Provider Bad Debt Payment

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

ACTION: Proposed rule.

SUMMARY: This proposed rule would remove the cap on allowable Medicare bad debt for end-stage renal disease (ESRD) facilities and expand the application of a 30 percent reduction in bad debt reimbursement for hospitals to other Medicare providers or entities currently eligible to receive bad debt reimbursement. In addition, this proposed rule would clarify that bad debts are not allowable for entities paid under reasonable-charge or fee schedule methodologies. The goal of this proposal, with respect to bad debt payment, is to achieve a consistent bad debt reimbursement policy for hospitals and other providers or entities currently eligible to receive payments from Medicare for bad debt.

DATES: We will consider comments if we receive them at the appropriate address, as provided below, no later than 5 p.m. on April 11, 2003.

ADDRESSES: In commenting, please refer to file code CMS–1126–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–1126–P, PO Box 8017, Baltimore, MD 21244–8017.

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: Katie Walker, (410) 786–7278.

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, phone (410) 786–7195 or (410) 786–7201. We must be contacted at least 72 hours in advance.

Copies: To order copies of the **Federal Register** containing this document, send your request to: New Orders, Superintendent of Documents, PO 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 $10. 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

A. Bad Debt Reimbursement

In 1966, the Health Insurance Benefits Advisory Committee (HIBAC) (authorized by section 1867 of the Social Security Act, repealed 1984) recommended that Medicare cover the unpaid deductible and coinsurance amounts that arose in connection with the provision of covered services to beneficiaries (herein referred to as Medicare bad debt). This recommendation was meant to avoid cross-subsidization that might occur if hospitals or other entities tried to recoup Medicare bad debt from other payers. The HIBAC believed that under the statute, the Congress had intended to avoid cross-subsidization by meeting the cost of the bad debts that accrued to a provider where these amounts were otherwise uncollectible. The reasoning behind this view flowed from section 1861(v)(1)(A)(i) of the Act, which states that the costs for individuals covered by the Medicare program must not be borne by individuals not covered by the program, and the costs for individuals not covered by the program must not be borne by Medicare. We refer to this statutory provision as the prohibition on cross-subsidization. The Secretary agreed with the HIBAC recommendation and the bad debt policy was adopted in 1966. This anti-cross subsidization principle is now part of the definition of ''reasonable cost'' as defined in section 1861(v) of the Act.

Under section 2145 of the Omnibus Budget Reconciliation Act (OBRA) of 1981 (Pub. L. 97–35), the Congress mandated a prospective payment system (PPS) for paying providers of various services covered by Medicare. Hospitals became the first provider-type to receive Medicare reimbursement under this law with the establishment of a PPS for inpatient hospital services in 1983. PPS replaced the retrospective cost-based reimbursement methodology previously in effect. Under this reimbursement system, Medicare payment for Part A inpatient operating costs is made on the basis of a prospectively determined rate per type of discharge, as determined by the classification of each patient case into a diagnosis-related group (DRG).

Shortly after implementation of PPS, in a Priority Audit Memorandum dated July 9, 1985, the Office of Inspector General (OIG) recommended that, in light of this new payment system, we should discontinue the reimbursement of inpatient hospital bad debts. After a thorough evaluation, we rejected the OIG's recommendation to discontinue paying bad debt for hospitals, concluding that the payments continued to be appropriate for the reasons discussed below. We also evaluated and rejected a second option suggested by the OIG to include a bad debt component in the DRG rates. We decided that this proposal would limit a hospital's incentive to collect the deductible and coinsurance amounts from the beneficiary and would address only the inpatient side. We also felt that because every facility incurred varying amounts of bad debt, the inclusion of bad debt in the DRG rates would be inequitable.

Therefore, in accordance with our regulations, we have continued to recognize bad debt for entities receiving payment under a PPS, such as for inpatient hospital services (42 CFR 412.115(a)), where Medicare payment policy, before PPS, recognized payment of those bad debts and where the prospective payments were derived from costs that did not reflect base period Medicare bad debts. That is, the prospective rates used to reimburse entities for services furnished to Medicare patients have basis in cost and are calculated using cost data reported by the entities on a base year cost report. They are then updated for inflation to the year in which payments are to be made. However, the bad debts incurred during that base period were not included in the calculation of the prospective rates. The bad debts for these entities are claimed at the end of each fiscal year, and allowable amounts are reimbursed separately.

Entities currently eligible to receive bad debt payments include hospitals, skilled nursing facilities (SNFs), critical access hospitals, rural health clinics, end-stage renal disease (ESRD) facilities, federally qualified health clinics, community mental health clinics, health maintenance organizations (HMOs) reimbursed on a cost basis, competitive medical plans (CMPs) and health care pre-payment plans.

The general bad debt policy is set forth in regulations at § 413.80 and the Provider Reimbursement Manual (PRM) (CMS Pub. 1501), Part 1, Chapter 3). Bad debt policy for ESRD Facilities is set forth in a separate regulation at § 413.178 and is further discussed below.

B. Reasonable Charge/Fee Schedules

The concept of Medicare bad debt payments applies only to services reimbursed on the basis of reasonable cost. Medicare has never made payments to account for bad debts for services paid under a fee schedule or reasonable charge methodology, such as services of physicians or suppliers. Under a fee schedule or reasonable charge methodology, Medicare reimbursement is not based on costs and, therefore, the concept of unrecovered costs is not relevant. Fee schedules, which are either charge-based or resource-based, relate payments to the price the entity charges. Historically, these prices have reflected the entities cost of doing business, including expenses such as bad debt.

C. End-Stage Renal Disease Bad Debt Reimbursement

Medicare pays ESRD facilities a prospectively determined composite rate. Under the payment rules authorized by sections 1881(b)(2) and (b)(7) of the Act as amended by OBRA of 1981, we pay 80 percent of a prospectively set rate for outpatient dialysis services. The Medicare beneficiary is responsible for the remaining 20 percent as a copayment, as well as any applicable deductible amounts set forth in § 413.176. If the ESRD facility makes reasonable collection efforts, as described in the PRM (CMS, pub. 15–1) Part I, (Section 310) but is unable to collect the coinsurance or deductible, we consider the uncollected amount to be a ''bad debt'' as described in §§ 413.178(b) and 413.80(b)(1) and (e).

At the end of the year, Medicare recognizes a facility's Medicare bad debts. However, under our current regulations, bad debt payments are capped so that total Medicare reimbursement (composite rate plus bad debt payments) does not exceed the total cost to serve Medicare patients.

Although section 1881 of the Act does not require Medicare to pay for an ESRD facility's Medicare bad debt, Medicare for many years (before the composite payment rate system) paid hospital-based ESRD facilities for their Medicare

bad debts, as it has long paid Medicare bad debts of other types of providers or entities that were paid on a reasonable-cost basis. By contrast, ''free-standing'' or independent ESRD facilities were paid on a reasonable charge basis and were expected to absorb any Medicare bad debt as part of that charge. When we developed the composite payment rate system, which is used to pay both hospital-based and free-standing ESRD facilities, we based payment on the results of audits of ESRD facilities' reported costs, exclusive of Medicare bad debts. For this reason, we decided it was appropriate to separately recognize these bad debts at the end of the facility's fiscal year. Under the authority granted us in section 1881(b)(7) of the Act, we considered two options for paying these bad debts. One option was to include the bad debt allowance in the calculation of the composite rate. The other option was to reimburse an ESRD facility's bad debts in a special payment at the end of the facility's cost accounting period. We decided that this latter option was preferable because it would allow us to pay each facility the exact amount of its allowable bad debts. We concluded that, under the statute, we could pay an ESRD facility for its bad debts incurred from providing services to Medicare beneficiaries, and thereby avoid indirectly passing on these bad debts to individuals not covered by Medicare. Similarly, we determined that it would be appropriate to cap the total bad debt payment at a facility's unrecovered costs. In this way, the combination of the composite rate payments and our payment, if any, for Medicare bad debts would not exceed the facility's total allowable cost of providing services to Medicare beneficiaries.

In 1994, a group of providers of outpatient renal dialysis services challenged our regulation at § 413.178(a), which caps reimbursement for an ESRD facility's bad debt at costs. The plaintiffs argued, among other things, that we had provided inadequate justification for the reimbursement cap and were unable to demonstrate that the cap was consistent with the statute, as required by the Administrative Procedure Act (APA) (5 U.S.C., 706(2)(A)). The U.S. District Court for the District of Columbia upheld our regulation as an acceptable exercise of our discretion under the APA. On appeal, however, the D.C. Circuit Court overturned the District Court's ruling and found that our explanation, relying on the statutory provisions relating to cross-subsidization discussed above, was inadequate justification for the rule and inconsistent with a prospective rate scheme (*Kidney Center of Hollywood et al.* v. *Shalala,* 133 F.3d 78,88 (D.C. Circuit 1998)). The Circuit Court ordered that the final rule be vacated and remanded the case to us with the instruction that we either more adequately justify the rule or jettison it altogether.

D. Legislation Affecting Bad Debt Reimbursement for Hospitals

1. Omnibus Reconciliation Act of 1987

In 1987, the Congress enacted section 4008(c) of the OBRA of 1987 and later amended it in sections 8402 of the Technical and Miscellaneous Revenue Act of 1988 and section 6023 of OBRA of 1989. The provision, as amended, prohibits us from making ''any change in the policy in effect on August 1, 1987, regarding reimbursement to hospitals for Medicare bad debts.'' This legislation is collectively referred to as the moratorium on changes to the Medicare bad debt policy for hospitals. Since its enactment, the moratorium has precluded us from making any changes to bad debt policy for hospitals, although the Congress has authorized subsequent changes through legislation. The moratorium does not apply to entities other than hospitals. Since the inception of the Medicare program, bad debt reimbursement for entities other than hospitals has been and continues to be at our discretion. According to *Kidney Center of Hollywood, et al.* v. *Shalala,* the Secretary's discretion on this matter is broad as long as it is authorized by statute and is rationally justified. Therefore, we believe any changes made to bad debt policy for these other entities can be implemented by regulation.

2. Balanced Budget Act of 1997

From 1989 to 1996, provider and entity cost report data showed an alarming growth in bad debt payments in the Medicare program. For hospitals alone, from 1990 to 1994, total Medicare bad debt payments grew 165 percent, from $415 million to $1.1 billion. During this period, the inpatient bad debts grew 140 percent, from $270 to $650 million, and Part B (primarily outpatient) bad debts tripled, from $140 to $430 million. In 1997, with increasing concern over the rapidly expanding payout for bad debts under Medicare, the Congress responded with section 4451 of the Balanced Budget Act (BBA) of 1997 (Pub. L. 105–33). Section 4451 of the BBA amended section 1861(v)(1) of the Act by adding section 1861(v)(1)(T). The legislation required that, in determining reasonable costs for hospitals, the amount of bad debts otherwise treated as allowable costs (attributable to deductibles and coinsurance amounts) should be reduced by 25 percent for fiscal year (FY) 1998, by 40 percent for FY 1999, and by 45 percent for subsequent years.

3. The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000

As a response to concerns from Medicare hospitals that the fiscal impact of this provision of the BBA was too harsh, the Congress enacted section 541 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (Pub. L. 106–554) (BIPA). This eased the reduction in hospital bad debt reimbursement from 45 percent to 30 percent. Although the Congress decreased the reduction of bad debt reimbursement for hospitals, the BIPA did not address the issue for other providers.

E. Impact Using Prospective Payment Systems on the Role of Bad Debt in Medicare Payment Systems

The introduction of the PPS has changed the context for Medicare's bad debt policy. The PPS for inpatient hospital services was introduced in 1983 out of a notion that cost reimbursement systems provided an incentive for providers to incur costs. The costs were passed along to Medicare automatically and provided no incentive for prudent and efficient management of hospital resources. This methodology provided no opportunity for hospitals to earn profit through efficiency. The DRG payments were intended to provide a context in which the hospitals that achieved savings through efficiency and innovative practices could profit from their efforts. In fact, the result of this change in payment system was that hospital Medicare margins (a rough measure of the extent to which payments exceeded actual costs) rose immediately and have continued to exceed pre-PPS levels.

In this context, making separate payments for uncollected Medicare deductible and coinsurance amounts is no longer an appropriate expression of Medicare's responsibility for reimbursement, especially in a marketplace where commercial insurers do not make similar adjustments in their payments. In fact, the availability of additional payment when debts are not collected provides an incentive to the provider to forego effective collection efforts in return for the certainty of Medicare payments. If Medicare did not recognize these payments, there would be a greater incentive for the hospitals

to attempt to collect from the beneficiary. We believe that the percentage reduction in bad debt reimbursement would be a step toward fostering this incentive for nonhospital entities.

Fiscal responsibility to the Medicare program is an important factor in implementing this rule. We believe that reducing the amount of Medicare bad debt reimbursement by 30 percent will encourage accountability and foster an incentive to be more efficient in bad debt collection efforts. We also believe strongly that Medicare bad debt policy should be applied consistently and fairly among all providers eligible to receive bad debt reimbursement. Currently, hospitals are the only entities experiencing a reduction in bad debt reimbursement. Furthermore, ESRD facilities are the only entities whose bad debt claims are capped at the facilities costs.

After considering the action of the Congress in setting the reduction in bad debt reimbursement at 30 percent for hospitals, we decided that the number used by the Congress in this action was an equitable and reasonable policy choice with respect to entities other than hospitals. Subsequently, we decided to draft a regulation that would advance a consistent bad debt reimbursement policy for all Medicare entities. To implement this rule, we propose to remove the cap on allowable bad debt for ESRD facilities and apply the 30 percent reduction in bad debt reimbursement that was legislated for hospitals to all Medicare providers or entities eligible to receive payments in recognition of Medicare bad debts. We propose to implement the reduction in bad debt incrementally (as the Congress chose to do to implement the BBA reduction for hospitals) over a 3-year period to mitigate the impact on entities. Again, as discussed above, we believe that the percentage reduction in bad debt reimbursement would be a step toward fostering an incentive for nonhospital entities to make conscientious, effective collection efforts on their unpaid Medicare patient accounts.

II. Provisions of the Proposed Rule

A. Removal of Cap on End-Stage Renal Disease Bad Debt Reimbursement

In accordance with the DC Circuit Court ruling discussed above and in order to be consistent with other entities as mandated in the President's 2003 budget, the cap on ESRD bad debt reimbursement should be removed.

This proposed rule would, therefore, remove the cap on ESRD bad debts and allow ESRD facilities to claim bad debts at an amount exceeding unrecovered costs.

B. Adjustment in Allowable Bad Debt Reimbursement to Hospital Levels

As discussed above, we propose to reduce the amount of allowable bad debt for entities other than hospitals by 10 percent for cost reporting periods beginning October 1, 2003, by 20 percent for cost reporting periods beginning October 1, 2004, and by 30 percent for cost reporting periods beginning October 1, 2005 and thereafter. The entities currently included in this proposal are SNFs, ESRD facilities, rural health clinics, critical access hospitals, community mental health clinics, and federally qualified health clinics. Cost HMOs/CMPs and health care pre-payment plans are excluded from the proposed 30 percent reduction as the bad debt reimbursement for these entities is already limited according to § 417.536. The unpaid deductible and coinsurance amounts for services rendered by these entities is limited to no more than 3 months of the premium (portion related to deductible and coinsurance) for any one individual. To be reimbursable, the deductible and coinsurance must relate to what is covered under Medicare and under our contract with the HMO/CMP. As discussed above, the incremental reduction over a 3-year period is intended to mitigate the impact on entities.

C. Confirmation of Bad Debt Policy for Services Paid Under a Charge-Based Methodology or Fee Schedule

This proposed rule would amend language in the existing bad debt regulations to clarify that bad debts are not recognized or reimbursed for any services paid under a reasonable charge-based methodology or a fee schedule. This clarification is not a change in policy.

III. Collection of Information Requirements

This document does not impose information collection and recordkeeping requirements. Consequently, it need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C.A. section 3506(c)(2)(A)).

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 rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 16, 1980, Pub. L. 96–354), section 1102(b) of the Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), and Executive Order 13132. We believe that this regulation would qualify as a major rule.

Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, if 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 major rules with economically significant effects ($100 million or more in any 1 year). We believe that this regulation would qualify as a major rule and that the impact would be economically significant.

Most ESRD facilities would benefit from this proposed rule, as they would be allowed to claim and receive reimbursement for more of their Medicare bad debts, allowing them to claim bad debts over their unrecovered costs.

Some entities, such as SNFs and rural health clinics, may experience a reduction in their bad debt reimbursement as a result of this rule. Data from SNF cost reports show bad debt totals of $8,244,192 for FYE 1996, $13,070,786 for FYE 1997 and $12,501,755 for 1998 (only settled cost report data was used and fewer cost reports were settled for 1998). Bad debt data for independent rural health clinics, federally qualified health centers and community mental health clinics is not captured because the independent facilities, which make up the majority of these entities, do not file electronic cost reports. The reduction in reimbursement would also affect critical access hospitals, which are defined under section 1820 of the Act and were not subject to the reduction in bad debt reimbursement imposed by the BBA on hospitals defined in section 1861(v)(1). Cost report data for critical access hospitals was badly skewed because of systems problems after November 1,

1997. Lab and outpatient services (which one Intermediary reports accounts for 30 to 40 percent of the revenue for critical access hospitals) for some of these entities were reimbursed on a cost basis with applicable coinsurance and deductible amounts, while some of these entities were paid under a fee schedule with no reimbursement for bad debts. As of November 29, 1999, coinsurance and deductibles were eliminated from lab services for critical access hospitals. We expect that this action will significantly reduce the amount of bad debt incurred by these facilities.

The following is the individual estimate of the economic impact of this rule between provider types (in $millions):

Fiscal year	SNF	ESRD	Net impact
2003	−20	20	0
2004	−30	20	10
2005	−70	20	50
2006	−90	20	70
2007	−100	20	80

The impact on all other provider types would round to $0. For both SNF and ESRD facilities, these savings or costs represent only a small portion (about 0.5%) of the total Medicare payments for those facilities.

Section 1102(b) of the Act requires us to prepare a regulatory impact analysis (RIA) 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. Although this rule would impact some small rural hospitals, including critical access hospitals, most hospitals have already been subject to the 30 percent reduction implemented by statute. We believe this rule would not have a significant impact on the operations of a substantial number of small rural hospitals and the impact would be mitigated by implementing the rule gradually over a 3-year period.

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 $6 million to $29 million annually. Intermediaries and carriers are not considered to be small entities.

Small rural hospitals of fewer than 100 beds, rural health clinics, community mental health centers, free-standing ESRD facilities, and hospital-based ESRD facilities would be affected by this rule. There are approximately 352 critical access hospitals, and all of these facilities would be small rural hospitals. To the extent that they incur bad debts, they would be affected. It is very difficult to assess the impact on these facilities because the impact, if any, on a facility would be influenced by the amount of bad debts the facility incurs. However, the elimination of coinsurance and deductible amounts for lab services rendered by critical access hospitals should substantially reduce the amount of bad debt that these small hospitals incur. Any Medicare participants that are currently receiving full (that is, uncapped) reimbursement for their bad debts would see a reduction in payment.

Based on current data, there are approximately 3,528 freestanding and 787 hospital-based ESRD facilities. Although we are not certain how many of these facilities are small rural hospital-based, most ESRD facilities would benefit from this rule as they would be allowed to claim and receive reimbursement for more of their Medicare bad debts, allowing them to claim bad debts over their unrecovered costs. Costs are difficult to estimate because, as discussed above, not all uncapped ESRD bad debts were reported. We welcome all comments that would assist us in determining the possible impact of this rule on any of the above-mentioned entities.

Specific provisions of this proposed rule have already been applied in part to those ESRD facilities affected by the above-mentioned *Kidney Center* court settlement. These provisions, whether implemented as a result of the court settlement or the rule, were achieved through modifications made to the bad debt settlement portion of the cost report.

We do not believe that the changes made in a final rule will affect beneficiary access to care, as affected providers will continue to be reimbursed for services provided to Medicare beneficiaries, including, where allowable, for Medicare bad debt. By reducing the amount of bad debt reimbursement from 100 percent to 70 percent, this rule will fairly compensate providers, while providing an incentive for them to make reasonable efforts to collect unpaid deductibles and coinsurance.

The analysis indicates that some small, rural providers may experience an additional burden in the form of reduced payments for bad debts. However, our analysis points out that a number of factors will mitigate the impact on small rural hospitals and that payments to ESRD facilities will increase because of the removal of the cap on allowable bad debts claimed. It is impossible to determine the significance of the impact or the number of entities that may be adversely affected. We invite comments on our analysis.

The Unfunded Mandates Reform Act of 1995 also requires (in section 202) that agencies perform an assessment of anticipated costs and benefits before proposing any rule that may result in an annual expenditure in any 1 year by State, local, or Tribal governments, in the aggregate, or by the private sector, of $110 million. This rule does not impose any mandates on State, local or Tribal governments, or on the private sector, as defined by section 202. Entities such as hospitals, SNFs and ESRD facilities will continue to receive Medicare reimbursement for services provided to beneficiaries, including, where allowable, bad debt reimbursement.

For purpose of analysis, we considered two alternatives to this policy, (1) maintaining the existing Medicare bad debt policy, or (2) eliminating bad debt reimbursement, where we had authority to do so. However, we believe that the Medicare bad debt policy proposed in this rule is equitable across provider types and ensures that providers have the incentive to make reasonable efforts to collect bad debts without affecting beneficiary access to care. In addition, the removal of the cap on bad debt reimbursement for ESRD facilities is also in accordance with the ruling in *The Kidney Center of Hollywood, et al.* v. *Shalala.*

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 requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. This rule would not have a substantial effect on State 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 in 42 CFR Part 413

Health facilities, Kidney diseases, Medicare, Puerto Rico, Reporting and record-keeping requirements.

For the reasons set forth in the preamble, CMS proposes to amend 42

CFR chapter IV part 413 as set forth below:

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

Subpart F—Specific Categories of Cost

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

Authority: Sections 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), 1395g, 1395l(a), (i), and (n), 1395hh, 1395rr, 1395tt, and 1395ww).

2. In § 413.80, paragraphs (h) and (i) are revised to read as follows:

§ 413.80 Bad debts, charity, and courtesy allowances.

* * * * *

(h)(1) *Limitations on bad debts for hospitals.* The amount of bad debts otherwise treated as allowable costs (as defined in paragraph (e) of this section) is reduced as follows for cost reporting periods beginning during:

(i) Fiscal year 1998, by 25 percent.

(ii) Fiscal year 1999, by 40 percent.

(iii) Fiscal year 2000, by 45 percent.

(iv) All subsequent fiscal years, by 30 percent.

(2) *Limitations on bad debts for other entities.* Except as provided in § 417.536 of this title, the amount of bad debts otherwise treated as allowable costs (as defined in paragraph (e) of this section) is reduced as follows for cost reporting periods beginning on or after:

(i) October 1, 2003, by 10 percent.

(ii) October 1, 2004, by 20 percent.

(iii) October 1, 2005 and all subsequent years, by 30 percent.

(i) *Exception.* Bad debts arising from services paid under a reasonable charge-based methodology or a fee schedule are not reimbursable under the program.

Subpart H—Payment for End-Stage Renal Disease (ESRD) Services and Organ Procurement Costs

3. In § 413.178, paragraph (a) is revised to read as follows:

§ 413.178 Bad debts.

(a) CMS will reimburse each facility its allowable Medicare bad debts, as defined in § 413.80(b)(1), as determined under Medicare principles, in a single lump sum payment at the end of the facility's cost reporting period. The amount of allowable bad debt is reduced in accordance with § 413.80(h)(2).

* * * * *

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

Dated: September 3, 2002.

Thomas A. Scully,

Administrator, Centers for Medicare & Medicaid Services.

Approved: January 2, 2003.

Tommy G. Thompson,

Secretary.

[FR Doc. 03–2974 Filed 2–3–03; 4:31 pm]

BILLING CODE 4120–01–P

FEDERAL COMMUNICATIONS COMMISSION

47 CFR Part 90

[WT Docket No. 02–55; DA 03–19]

Supplemental Comments of the Consensus Parties Filed in the 800 MHz Public Safety Interference Proceeding; Request for Comments

AGENCY: Federal Communications Commission.

ACTION: Proposed rule; request for comments.

SUMMARY: This document seeks comment on ''Supplemental Comments of the Consensus Parties'' filed in the 800 MHz Public Safety Interference Proceeding—WT Docket No. 02–55. The Bureau, by this action, affords interested parties an opportunity to submit comments and reply comments that will improve public safety operations in the 800 MHz band. Improving public safety operations in the 800 MHz band will reduce interference experienced by 800 MHz public safety operators.

DATES: Comments are due on or before February 3, 2003 and Reply Comments are due on or before February 18, 2003.[1]

ADDRESSES: Federal Communications Commission 445, 12th Street, SW., TW–A325, Washington, DC 20554. *See* **SUPPLEMENTARY INFORMATION** for filing instructions.

FOR FURTHER INFORMATION CONTACT: Karen Franklin, Esq. or Michael J. Wilhelm, Esq., Policy and Rules Branch, Public Safety and Private Wireless Division at (202) 418–0680.

SUPPLEMENTARY INFORMATION: This is a summary of the Commission's Public Notice, DA 03–19, released on January 3, 2003. The full text of this document is available for inspection and copying during normal business hours in the FCC Reference Center, 445 12th Street, SW., Washington, DC 20554. The complete text may be purchased from the Commission's copy contractor, Qualex International, 445 12th Street, SW., Room CY–B402, Washington, DC. 20554. The full text may also be downloaded at: *www.fcc.gov.* Alternative formats are available to persons with disabilities by contacting Brian Millin at (202) 418–7426 or TTY (202) 418–7365 or at *bmillin@fcc.gov.*

On December 24, 2002, a group of sixteen parties filed ''Supplemental Comments of the Consensus Parties'' in WT Docket 02–55, Improving Public Safety Communications in the 800 MHz Band—Consolidating the 900 MHz Industrial/Land Transportation and Business Pool Channels (67 FR 16351, April 5 2002). [2] In these comments, the parties provide additional details concerning the ''Consensus Plan'' for addressing interference issues in the 800 MHz band. In order to develop a full and complete record, the Wireless Telecommunications Bureau issues this public notice seeking comment on the Supplemental Comments of the Consensus Parties (Supplemental Comments). The Commission will accept comments on the Supplemental Comments on or before February 3, 2003; and reply comments on or before February 18, 2003.

The Supplemental Comments primarily address four issues: (1) Funding for the Consensus Plan; (2) procedures and processes for relocating 800 MHz incumbents; (3) post-realignment interference protection standards; and (4) border area realignment plans.

Interested parties may view the ''Supplemental Comments of the Consensus Parties'' on the Commission's Electronic Comment Filing System (ECFS) using the following steps: (1) Access ECFS at *http://www.fcc.gov/e-file/ecfs.html.* (2) In the introductory screen, click on ''Search for Filed Comments.'' (3) In the ''Proceeding'' box, enter ''02–55.'' (4) In the ''Filed on Behalf of'' box, enter ''Consensus Parties.'' (5) In the ''Date Submitted'' box, enter ''12/24/2002.'' In addition, the Supplemental Comments of the Consensus Parties will be available for inspection and duplication during regular business hours in the FCC Reference Information Center (RIC) of the Consumer and Governmental Affairs Bureau, Federal

[1] This document was received at the Office of the Federal Register on February 5, 2003.

[2] Subsequent to issuance of the public notice, the comment and reply comment dates were extended to February 10, 2003 and February 25, 2003, respectively (published elsewhere in this issue). *See* Improving Public Safety Communications in the 800 MHz Band and Consolidating the 800 MHz Industrial Land Transportation and Business Pool Channels, *Order Extending Time for Filing of Comments*, WT Docket 02–55, DA 03–163 (January 16, 2003)