B. Anticipated Effects

1. Effects on Beneficiaries

Before October 1, 2000, disabled beneficiaries who returned to work received 24 additional months of Medicare coverage following the 15th month of their re-entitlement period. Effective October 1, 2000, these beneficiaries receive 78 months of Medicare coverage following the 15th month of the re-entitlement period.

2. Effects on the Medicare Programs

Anticipated expenditures to the Medicare program have been projected over a 5-year period and are shown in the following chart:

Year	2004	2005	2006	2007	2008
Cost [1]	100	110	130	140	160
Disabled individuals affected [2]	35,000	39,000	42,000	45,000	48,000

[1] Rounded to the nearest 10 million.
[2] Rounded to nearest thousand.

C. Alternatives Considered

We considered excluding individuals whose disability benefit entitlement, and thus Medicare coverage, should have ended September 30, 2001 or earlier, but determined that it would be appropriate to extend the additional Medicare coverage to all beneficiaries who were entitled to Medicare as of October 1, 2000. The aggregate economic effect of this approach is negligible.

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

List of Subjects Affected in 42 CFR Part 406

Health facilities, Medicare.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services proposes to amend 42 CFR, chapter 4, part 406, subpart B as set forth below:

PART 406—HOSPITAL INSURANCE ELIGIBILITY AND ENTITLEMENT

Subpart B—Hospital Insurance Without Monthly Premiums

1. The authority citation for part 406 continues to read as follows:

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

2. In § 406.12, revise the introductory text to paragraph (e)(2) and revise paragraph (e)(2)(i) to read as follows:

§ 406.12 Individual under age 65 who is entitled to social security or railroad retirement disability benefits.

* * * * *

(e) * * *

(2) *Duration of continued Medicare entitlement.* If an individual's entitlement to disability benefits or status as a qualified disabled railroad retirement beneficiary ends because he or she engaged in, or demonstrated the ability to engage in, substantial gainful activity after the 36 months following the end of the trial work period, Medicare entitlement continues until the earlier of the following:

(i) The last day of the 78th month following the first month of substantial gainful activity occurring after the 15th month of the individual's re-entitlement period or, if later, the end of the month following the month the individual's disability benefit entitlement ends.

* * * * *

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

Dated: November 1, 2002.

Thomas A. Scully,

Administrator, Centers for Medicare & Medicaid Services.

Dated: March 26, 2003.

Tommy G. Thompson,

Secretary.

[FR Doc. 03–19068 Filed 7–24–03; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 424

[CMS–1185–P]

RIN 0938–AK79

Medicare Program; Elimination of Statement of Intent Procedures for Filing Medicare Claims

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

ACTION: Proposed rule.

SUMMARY: This proposed rule would remove the written statement of intent (SOI) procedures used to extend the time for filing Medicare claims. One of the goals of our regulatory reform efforts is to update our regulations based on recent experiences with filing practices and changes in the law. The SOI procedures extend the time to file a claim by 6 months after the month in which a Medicare contractor acknowledges the receipt of a valid statement of intent. We are proposing to remove the SOI procedures because beneficiaries, whom the SOI procedures were intended to benefit, rarely file claims or SOIs. Instead, SOIs are filed in great numbers on behalf of, especially, dually-eligible beneficiaries by States that have previously made Medicaid payments, and occasionally by providers and suppliers. The large number of SOIs imposes a significant expenditure of resources on our contractors, and may also be due to, in part, a lack of careful screening as to whether claims should have initially been presented to and paid by Medicaid. In the absence of an SOI, providers and suppliers (and, where applicable, beneficiaries) would still have from 15–27 months (depending on the date of service) to file claims with Medicare contractors.

DATES: We will consider comments if we receive them at the appropriate address, as provided below, no later than 5 p.m. on September 23, 2003.

ADDRESSES: In commenting, please refer to file code CMS–1185–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–1185–P, P.O. Box 8014, Baltimore, MD 21244–8014.

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 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201, or Room C5–14–03, 7500 Security Boulevard, Baltimore, MD 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 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: *David Walczak,* (410) 786–4475.

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. by calling (410) 786–7197.

I. Background

The purpose of the statement of intent (SOI) procedures is to extend the timely filing period for the submission of an initial Medicare claim. An SOI, by itself, does not constitute a claim, but rather is a means of extending the deadline for filing a timely and valid claim. Our regulations at 42 CFR 424.32, ''Basic requirements for all claims,'' and § 424.44, ''Time limits for filing claims,'' require that Medicare claims be filed on Medicare-designated claims forms by providers, suppliers, and beneficiaries according to Medicare instructions, by the end of the year following the year in which the services were furnished. Services furnished in the last 3 months of a calendar year are deemed to be furnished in the subsequent calendar year, and thus, in this situation, a provider, supplier, or beneficiary has until December 31 of the second year following the year in which the services were furnished to file claims. Where an SOI has been filed with the appropriate Medicare contractor and the contractor notifies the submitter of the SOI that the SOI is valid (that is, the SOI sufficiently identifies the beneficiary and the items or services rendered), the period in which to file a claim may be extended an additional 6 months after the month of the contractor's notice.

The original regulation on extending the time to file claims for Medicare benefits was codified at 20 CFR 405.1693, and was based on 20 CFR 404.613, which pertained to applications for Social Security benefits. Section 404.613 reflected the Social Security program's interest in allowing virtually any type of writing to be a placeholder for filing a claim for Social Security benefits, provided that a perfected claim was submitted shortly thereafter. Because we believed that Medicare beneficiaries might sometimes need extra time to file a Part B claim due to extenuating circumstances such as poor health or unfamiliarity with the claims filing process, we instituted the SOI procedures.

Experience has shown, however, that beneficiaries rarely submit SOIs directly. Medicare contractors that we surveyed reported no SOIs were directly submitted by beneficiaries for the claims filing period ending December 31, 2000, the latest year for which we have complete data. One reason for the lack of beneficiary-initiated SOIs is the fact that beneficiaries rarely need to file claims. The percentage of Part B claims taken on assignment is about 98 percent today, compared to about 52 percent in 1975. (''Assignment'' is the process by which the physician or other supplier agrees to accept Medicare payment in full for a Part B item or service and file the claim for such payment.) Even for Part B claims not taken on assignment, the law now requires the physician or other supplier to file the claim and provides for sanctions for failure to do so. (*See* section 1848(g)(4) of the Act (42 U.S.C. 1395w–4(g)(4)). The number of Part A claims filed by beneficiaries has always been minimal because the law requires that payment for Part A services generally be made only to providers of services, with very limited exceptions. (*See* section 1814(a) of the Act (42 U.S.C. 1395f(a)). Thus, we believe that the SOI procedures are no longer necessary insofar as they are not serving their intended purpose.

Further, we believe retention of the SOI procedures is counterproductive because of the amount of resources needed to process SOIs submitted by States and because the SOI procedures may encourage or facilitate inappropriate behavior on the part of some States and some providers.

Each year, our contractors receive an enormous number of SOIs that are submitted by States that, having first made Medicaid payments to dually-eligible (that is, Medicare and Medicaid) beneficiaries, subsequently believe that Medicare should be the proper payor. Subsequent to several court decisions in the early 1990s, we permitted States to ''stand in the shoes'' of a dually-eligible beneficiary with respect to claims filing and appeals. For example, States are not required to obtain a beneficiary's signature in order to request providers to file a Part A claim or in order to file an appeal. We also have permitted States and their contractors to file SOIs on the States' behalf or as appointed representatives of the beneficiaries.

The great majority of these SOIs are filed on paper and thus must be manually processed to determine whether they are valid SOIs. (According to our requirements, SOIs must contain detailed and specific information to ensure that a subsequently filed claim was in fact protected by an SOI. (See Program Memorandum AB–03–61)). Also, these SOIs are typically filed in large batches near the end of the timely filing period. All of these factors contribute to the amount of resources and consequent cost incurred in processing the SOIs.

We also believe that the SOI procedures may contribute to States ''paying and chasing'' instead of following the required cost-avoidance procedures, and to the incorrect submission of claims to Medicaid by providers. Our regulations at § 433.139(b) provide that, unless a waiver is granted under § 433.139(e), a State Medicaid agency that has established the probable existence of third party liability (including Medicare liability) at the time a claim for Medicaid payment is presented to it, must reject the claim and return it to the provider for a determination of liability. This process is known as cost avoidance. Some States, however, have been paying thousands of Medicaid claims, despite the knowledge that the beneficiaries involved are entitled to Medicare. These States subsequently identify a significant portion of the claims that they have paid as ones for which Medicare should be the proper payor, and use the SOI procedures to extend the time for providers to file claims.

The fact that such large numbers of claims are paid first by Medicaid and then identified as payable by Medicare raises the inference that providers are not as careful as they should be as to which payor they initially submit claims, and that States, by initially paying such claims, are not fully practicing cost avoidance. We are concerned that the availability of the SOI procedures to extend the time for filing claims is contributing to such inappropriate behavior. We also note that many of the claims filed with Medicare subsequent to the SOIs are ''demand bills,'' which require full medical review, thus increasing the

claims processing cost for our contractors. (Where a provider believes that a service is not covered by Medicare but the beneficiary (or the State as the beneficiary's subrogee) requests the provider to bill Medicare regardless, the provider's Medicare provider agreement requires it to bill Medicare. Such a bill is known as a ''demand bill.'' It requires full medical review because the fact that the provider initially believed that the service was not covered by Medicare raises the question of whether Medicare should pay it.)

Finally, we are cognizant that providers and suppliers sometimes file SOIs. We believe, however, that the filing periods in § 424.44 (15 to 27 months, depending on the date the service was rendered) are more than an adequate amount of time to submit claims.

Based on a survey of SOI requests filed with Medicare contractors for the claims filing period that ended December 31, 2001 (the latest year for which data was available), a very small percentage of claims were processed and paid compared to the total number of SOI requests received. The entire process of receiving an SOI request, determining if an SOI is valid or invalid, examining a later-submitted claim to determine whether the claim was in fact protected by the earlier-submitted SOI, and adjudicating the claim (which, in many cases involves full medical review) are all done manually, and the costs associated with such manual processing are not included in our contractors' budgets (contractors are not required to calculate costs at this level). Therefore, the expenditure of resources and money for such manual processing takes away from the resources needed to do the activities and functions that are included in our contractors' budgets. This proposed rule, if finalized, should have little financial impact on entities that currently submit SOI requests. The rule would simply require these entities to submit their claims six months or so earlier, to comply with Medicare's timely filing requirements (that is, 15 to 27 months after the date of service, depending on the particular month the service was rendered). Given that the requirements for submitting a claim are not much different than submitting a valid SOI, and given that an SOI must be filed within the timely filing period, we anticipate no significant difficulty for such entities to timely submit claims.

Therefore, for the above reasons, we propose removing § 424.45 from our regulations.

II. Provisions of the Proposed Regulation

This regulation proposes to remove 42 CFR 424.45. In the absence of § 424.45, providers, suppliers and beneficiaries still would have from 15–27 months to submit claims to Medicare.

III. Collection of Information Requirements

This document does not impose new information collection and recordkeeping requirements but does remove an old one.

The elimination of §424.45 will reduce costs and workload burdens on providers and suppliers. Specifically, by eliminating the written SOI procedures, we hope to: (1) Reduce provider, supplier and Medicare contractor resource burdens; (2) reduce the burden placed on providers and suppliers from having to resubmit claims, and also from having to reimburse States for claims that were incorrectly paid for by the States; (3) reduce Medicare contractor administrative costs; (4) eliminate changes to existing intermediary/carrier claims payment systems; (5) encourage States to pursue cost-avoidance procedures to ensure that Medicaid is truly the payor of last resort, and thus reduce the need to use ''pay and chase'' procedures; (6) reduce the necessity for medical review at the contractor level; (7) strengthen Medicare and Medicaid program integrity efforts to ensure correct payment the first time; and (8) improve coordination efforts between the Medicare and Medicaid programs.

Given that CMS, in the past, did not specifically quantify the burden associated with this regulatory requirement, we are seeking public comment on the burden reduction associated with the elimination of section 42 CFR 424.45.

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

Centers for Medicare & Medicaid Services, Office of Strategic Operations and Regulatory Affairs, DRDI, DRD–B, Baltimore, MD 21244–1850, ATTN: Julie Brown, CMS–1185-P; and

Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503, ATTN: Brenda Aguilar, CMS Desk Officer CMS–1185-P.

Comments submitted to OMB may also be emailed to the following address: email: *baguilar@omb.eop.gov*; or faxed to OMB at (202) 395–6974.

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 19, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1955 (Pub. L. 104–4), and Executive Order 13132.

Executive Order 12866 (as amended by Executive Order 13258, which merely reassigns responsibility of duties) 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 annually). This is not a major rule. This proposed rule will have no substantial economic impact on either costs or savings to the Medicare or Medicaid programs.

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 government 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 (*see* 65 FR 69432). Individuals and States are not included in the definition of small entities.

In addition, 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 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital located outside of a Metropolitan Statistical Area with fewer than 100 beds.

We are not preparing analyses for either the RFA or section 1102(b) of the Act because we have determined, and we certify, that this rule will not have a significant impact on a substantial number small entities or rural hospitals because providers and suppliers will still have 15 to 27 months to file claims. Although some providers and suppliers may be small entities or rural hospitals, they are not filing a significant number of SOIs and the information required to file a valid SOI is essentially the same information that providers and suppliers are required to provide when filing a valid claim. We are aware that some States rely on the SOI process at the end of the period for Medicare timely claims filing, to pay and recover expenditures for some of their claims that could have been paid by Medicare. Elimination of the SOI process will require that these States revert to the standard recovery process in the Medicaid regulations to assure that claims are filed within the (15–27 months) Medicare timely filing requirements. While the elimination of the SOI process will not completely eliminate the issue of ''pay and chase,'' we believe it will encourage States to pursue cost-avoidance procedures to ensure that Medicaid is truly the payer of last resort, reducing the need to use ''pay and chase'' procedures. We solicit comment on the impact of this regulation on States and providers.

Section 202 of the Unfunded Mandates Reform Act of 1995 requires that agencies assess anticipated costs and benefits before issuing any rule that may result in an expenditure in any one year by State, local, or tribal governments, in the aggregate, or by the private sector, of $110 million. This rule would not have such an effect on State, local, or tribal governments, or on the private sector.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule that would impose substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications.

While this rule would not have a substantial effect on State and local governments, States need to preserve their ability to appropriately recover expenditures for Medicaid benefits that should have been paid by Medicare. We are aware that some States rely on the SOI process, at the end of the period for Medicare timely claims filing, to recover expenditures for some of their claims that could have been paid by Medicare. Elimination of the SOI process will require that these States revert to the standard recovery process in the Medicaid regulations to assure that claims are filled within the (15–27 months) Medicare timely filing requirements.

For the reasons discussed earlier in this regulation, we believe this time frame is adequate to address the States' need for recovering claims from Medicare. We will continue to address the States' concerns on these payment and recoupment issues, through the efforts of the State Technical Advisory Group (TAG) on Third Party Liability, and will continue to consult with States about issues affecting their ability to recover expenditures for some of their claims that should have been covered by Medicare.

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 424

Emergency medical services, Health facilities, Health professions, Medicare, Reporting and recordkeeping requirements.

PART 424—CONDITIONS FOR MEDICARE PAYMENT

Part 424 is amended as follows:

1. The authority citation for part 424 continues to read as follows:

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

§ 424.45 [Removed]

2. Section 424.45 is removed.

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

Dated: December 20, 2002.

Thomas A. Scully,

Administrator, Centers for Medicare & Medicaid Services.

Approved: April 18, 2003.

Tommy G. Thompson,

Secretary.

[FR Doc. 03–18994 Filed 7–24–03; 8:45 am]

BILLING CODE 4120–01–P

FEDERAL COMMUNICATIONS COMMISSION

47 CFR Parts 1, 22 and 90

[WT Docket No. 03–103; FCC 03–95]

Rules To Benefit the Consumers of Air-Ground Telecommunications Services; Biennial Regulatory Review

AGENCY: Federal Communications Commission.

ACTION: Proposed rule.

SUMMARY: In this document, the Commission seeks comment on its rules governing the provision of air-ground telecommunications services on commercial airplanes in order to enhance the options available to the public. The Commission also proposes to revise or eliminate certain Public Mobile Services (PMS) rules that have become obsolete as the result of technological change, increased competition in the Commercial Mobile Radio Services (CMRS), supervening changes to related rules, or a combination of these factors. In addition, the Commission proposes to recodify and amend several rules, and make several conforming amendments to the Commission's rules. The Commission also seeks comment on providing licensees of nationwide paging channels flexibility to provide other services and on whether rules limiting the provision of dispatch service by paging licensees are too restrictive.

DATES: Comments are due on or before September 23, 2003, and reply comments are due on or before October 23, 2003.

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

FOR FURTHER INFORMATION CONTACT: Richard Arsenault, Commercial Wireless Division, Wireless Telecommunications Bureau, at (202) 418–0920, e-mail *richard.arsenault@fcc.gov.*

SUPPLEMENTARY INFORMATION: This is a summary of the Commission's Notice of Proposed Rulemaking, FCC 03–95, in WT Docket No. 03–103, adopted on April 17, 2003, and released on April 28, 2003. The full text of this document is available for inspection and copying during normal business hours in the FCC Reference Information Center, 445 12th Street, SW., Washington, DC 20554. The complete text may be purchased from the FCC's copy contractor, Qualex International, 445 12th Street, SW., Room CY–B402, Washington, DC 20554. The full text may also be downloaded at: *http://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.*

1. In this Notice of Proposed Rulemaking (NPRM), the Commission undertakes a fundamental reexamination of its rules governing the