

these requirements, particularly the requirement to identify the class of work to which the testimony is responsive. Requests to testify that do not conform to these requirements will not be considered, since the hearing sessions will be structured around particular or related proposed classes of works to be exempted. Persons who submit a timely request to testify will receive a response by email or telephone by April 14, 2003. The Copyright Office will notify all witnesses of the date and expected time of their appearance, and the time allocated for their testimony.

At the UCLA School of Law, only limited on-site parking will be available for participants and the public. Persons wishing to attend the hearings are encouraged to make alternative transportation plans or to park in commercial parking lots located near UCLA. The Office will post additional information on parking at UCLA on the Copyright Office's Web site at <http://www.copyright.gov/1201/>.

Addresses for Requests to Testify

All requests to testify must be sent by email to 1201@loc.gov and must be received by 5 E.S.T. on April 8, 2003. Persons who are unable to send requests by email should contact Rob Kasunic, Senior Attorney, at (202) 707-8380 to make alternative arrangements for submission of their requests to testify.

Form and Limits on Testimony at Public Hearings

There will be time limits on the testimony allowed for persons testifying that will be established after receiving all requests to testify. In the written comment period, the Office received nearly 400 written comments. Given the time constraints, only a fraction of that number could possibly testify at the hearings. A timely request to testify does not guarantee an opportunity to testify at these hearings. The Copyright Office encourages parties with similar interests to select common representatives to testify on behalf of a particular position.

The Copyright Office stresses that factual arguments are at least as important as legal arguments and encourages persons who wish to testify to provide demonstrative evidence to supplement their testimony. While testimony from attorneys who can articulate legal arguments in support of or opposition to a proposed exempted class of works is useful, testimony from witnesses who can explain and demonstrate the facts is also solicited. Any electronic or audiovisual equipment necessary for a presentation or demonstration at these California

hearings should be brought by the person testifying.

The Office intends to organize individual sessions of the hearings around particular or related classes of works proposed for exemption. If a request to testify involves more than one proposed exemption or related exemption, please specify, in order of preference, the proposed exemptions on which you would prefer to testify.

Following receipt of the requests to testify, the Copyright Office will inform all parties requesting to testify whether they have been accepted. The Copyright Office will also prepare an agenda of the hearings which will be posted on the Copyright Office Web site at <http://www.copyright.gov/1201/> and sent to persons who have been accepted to testify. To facilitate this process, it is essential that all of the required information listed above be included in a request to testify.

Dated: March 31, 2003.

David O. Carson,
General Counsel.

[FR Doc. 03-8147 Filed 4-1-03; 8:45 am]

BILLING CODE 1410-31-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 440

[CMS-2132-P]

RIN 0938-AM26

Medicaid Program; Provider Qualifications for Audiologists

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

ACTION: Proposed rule.

SUMMARY: This proposed rule would revise the requirements for audiologists furnishing services under the Medicaid program. In addition, it would create consistency with the Medicare requirements that define a qualified audiologist by recognizing the role of State licensure in determining provider qualifications. These revised standards would expand State flexibility in choosing qualified audiologists.

DATES: We will consider comments if we receive them at the appropriate address, as provided below, no later than 5 p.m. on June 2, 2003.

ADDRESSES: In commenting, please refer to file code CMS-2132-P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission or e-mail.

Mail written comments (one original and two copies) to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-2132-P, P.O. Box 3016, Baltimore, MD 21244-3016.

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 two 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 persons 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:
Linda Peltz, (410) 786-3399.

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.

Copies: 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. Legislation

Medicaid Requirements

Title XIX of the Social Security Act (the Act) authorizes Federal grants to States for Medicaid programs that

provide medical assistance to low-income families, the elderly, qualified pregnant minors, and persons with disabilities. The Medicaid program is jointly financed by the Federal and State governments and administered by the States. Within Federal rules, each State chooses eligible groups of beneficiaries, types and ranges of services, payment levels for services, and administrative and operating procedures. The nature and scope of a State's Medicaid program is described in the State plan that the State submits to us for approval. The plan is amended whenever necessary to reflect changes in Federal or State law, changes in policy, or court decisions. Under section 1902(a)(10) of the Act, States must provide certain basic services. Section 1905(a) of the Act identifies categories of services States may provide as medical assistance.

Under the Medicaid program, services for individuals with speech, hearing, and language disorders historically have been permitted under the Secretary's discretionary authority under section 1905(a)(11) of the Act. In our regulations, at 42 CFR 440.110(c), we require that the beneficiary be referred by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law for services furnished by, or under the direction of, a qualified audiologist or speech pathologist. As currently defined at § 440.110(c)(2), an audiologist or speech pathologist is an individual who has a certificate of clinical competence from the American Speech-Language-Hearing Association (ASHA); completed the equivalent educational requirements and work experience necessary for the certificate; or completed the academic program and is acquiring supervised work experience to qualify for the certificate.

Medicare Requirements

Section 1861(l)(2) of the Act defines audiology services to include hearing and balance assessment services furnished by a qualified audiologist, as the audiologist is legally authorized to perform under State law. Section 1861(l)(3)(B) then identifies the minimum qualifications that a qualified audiologist must have to participate in the Medicare program by defining a "qualified audiologist" as an individual with a master's or doctoral degree and who—

- Is licensed as an audiologist by the State in which the individual furnished those services; or
- In the case of an individual who furnishes services in a State that does not license audiologists, has—

- + Successfully completed 350 clock hours of supervised clinical practicum (or is in the process of accumulating that supervised clinical experience);
- + Performed not fewer than 9 months of supervised full-time audiology services after obtaining a master's or doctoral degree in audiology or a related field; and
- + Successfully completed a national examination in audiology approved by the Secretary.

B. Current Medicaid Program Experience

Since its inception, the Medicaid program has permitted States the option of providing services for individuals with speech, hearing, and language disorders. Audiology services may be provided in a variety of settings at the State discretion. States have the option of providing audiology services to their adult Medicaid population, but because of the mandatory Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program, must provide audiology services to Medicaid eligible persons under 21 years of age who have been evaluated and found in need of the service. In fact, Medicaid pays for a substantial number of medical services provided to children with disabilities in schools ("school-based services") according to the Individuals with Disabilities Education Act (IDEA) (Pub. L. 105-17, enacted on June 4, 1997). Our current regulations at § 440.110(c)(2), require audiologists to hold a certificate of clinical competency from ASHA, or its equivalent, to furnish audiology services. Current regulations also permit services to be provided under the direction of a qualified (ASHA certified) audiologist.

C. Consistency with Medicare Program

Before the Social Security Amendments of 1994 (Pub. L. 103-432, enacted on October 31, 1994), the Medicare and Medicaid regulations both required speech pathologists and audiologists to meet the academic and clinical experience requirements for a Certificate of Clinical Competence granted by ASHA. In accordance with section 146 of the Social Security Amendments of 1994, Medicare revised its statutory requirements for speech pathologists and audiologists, removing the requirement for ASHA certification and placing primary reliance for determining provider qualifications on State licensure.

After the revision of the Medicare requirements in 1994, we began receiving letters from audiology professionals and interested parties recommending that we adopt the

Medicare definition of qualified audiologists. In addition, the introductory text of the legislation entitled "The Medicaid Audiology Act of 1999" (H.R. 1068); and the Committee Report for FY 2001 Labor, Health and Human Services, and Education Appropriations bill (Report 106-645, page 108), recommended that we adopt the Medicare definition of "qualified audiologist" in the Medicaid program; that is, recognize the role of State licensure in determining provider qualifications. The proponents recommending the change stated that the Medicaid definition had not changed in over 20 years and predated the national trend toward greater reliance on State determinations of professional qualifications through licensure.

Last year, after repeated requests to reconcile the differing definitions, we agreed to consider possibilities for changing the Medicaid regulations to bring them into closer conformity with the Medicare requirements by recognizing State licensure in defining a qualified audiologist in a manner that would not compromise State flexibility and quality of care.

We began by conducting meetings with stakeholders and interviewing national organizations to determine the implications that this change would have on Medicaid programs, providers, and beneficiaries. Based on the information gained from those encounters, we now believe it is possible to enact a change to the Medicaid definition of qualified audiologist to recognize the role of State licensure, while simultaneously incorporating standards that address our concerns regarding quality standards of care.

The requirements proposed in this rule reflect our goal of maintaining Medicaid's quality standards while simultaneously being responsive to States, stakeholders, and beneficiaries. Our proposed provider standards recognize the role of State licensure in determining provider qualifications, while preserving the State's flexibility and professional industry standards that aid in ensuring quality services to all Medicaid beneficiaries.

II. Provisions of the Proposed Regulations

This proposed rule only addresses the qualifications of audiologists as defined under § 440.110(c)(2). At this time, we do not propose to change the requirements under this section pertaining to qualified speech-language pathologists.

We are proposing to make the following revisions to the regulations:

- In § 440.110(c)(2), to define audiologists separately from speech pathologists.

- To add a new § 440.110(c)(3) to define “qualified audiologist”. “A qualified audiologist means an individual with a master’s or doctoral degree in audiology who—

(i) Is licensed as an audiologist to perform those services by the State in which the individual furnishes those services, providing that the State licensure requirements meet or exceed the requirements in paragraph (c)(3)(ii)(A) or (c)(3)(ii)(B) of this section;”.

(ii) In the case of an individual who furnishes audiology services in a state that does not license audiologists or that exempts audiologists practicing in specific institutions or settings from licensure, the individual must meet one of the following standards:

(A) Has a Certificate of Clinical Competence in Audiology granted by the American Speech-Language-Hearing Association; or

(B) Has successfully completed a minimum of 350 clock-hours of supervised clinical practicum (or is in the process of accumulating such supervised clinical experience under the supervision of a qualified master or doctoral-level audiologist), performed not less than 9 months of supervised full-time audiology services after obtaining a master’s or doctoral degree in audiology, or a related field, and successfully completed a national examination in audiology approved by the Secretary.

Similar to Medicare’s statutory revision in 1994, our proposed regulation will remove the requirement for ASHA certification as the sole standard for determining provider qualifications and will place primary reliance on State licensing.

Our goal in revising the Medicaid audiology provider qualification standards is to make both programs’ requirements consistent where possible while also incorporating minimum clinical and academic requirements that reflect nationally recognized industry professional standards. In doing so, we seek to ensure that regardless of where the Medicaid beneficiary receives the audiology services, the services would be provided by highly trained professionals.

To accomplish this goal, our proposed requirements differ from Medicare’s through the inclusion of minimum provider academic and clinical practicum standards applicable in States that license audiologists, as well as in

States that either exempt audiologists from licensure or that do not license audiologists at all.

“Under the Direction of”

To afford States the flexibility they currently have under Medicaid to determine qualified providers, we plan to retain the alternative requirement for providers who are not themselves qualified audiologists to work “under the direction of” a qualified audiologist. Section 440.110(c)(1) allows for services to be furnished by or “under the direction of” a qualified audiologist. This means an individual who is working under the supervision of a Federally qualified audiologist may furnish Medicaid audiology services.

We interpret the “under the direction of” requirement to mean that a qualified audiologist who is directly affiliated with the entity providing audiology services must supervise each beneficiary’s care. To meet this requirement, an audiologist must see the beneficiary initially, prescribe the type of care provided, and review the need for continued services throughout treatment. The audiologist must assume professional responsibility for the services provided and ensure that the services are medically necessary. The concept of professional responsibility implicitly supports face-to-face contact by the audiologist at least at the beginning of treatment and periodically thereafter. Thus, audiologists must spend as much time as necessary directly supervising services to ensure beneficiaries are receiving services in a safe and efficient manner in accordance with accepted standards of medical practice.

For an audiologist to be affiliated with an entity, there must be a contractual agreement or some other type of formal arrangement between the audiologist and the entity which enumerates the audiologist’s supervisory obligations relating to the care provided to the beneficiaries. Moreover, documentation must be kept supporting the audiologist’s supervision of services and ongoing involvement in the treatment. As stated above, we would retain the provision regarding services provided under the direction of an audiologist.

III. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we 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 by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

We are soliciting public comment on each of these issues for the provisions summarized below that contain information collection requirements: § 440.110 Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders.

Section 440.100(c)(3)(iii) states that an individual who provides Medicaid audiology services must maintain documentation to demonstrate that they meet the standard(s) set forth in this section. While this requirement is subject to the PRA, we believe this requirement is a usual and customary business activity and the burden associated with this requirement is exempt from the PRA, as stipulated under 5 CFR 1320.3(b)(2) and (b)(3).

If you comment on any of these information collection and record keeping requirements, please mail copies directly to the following: Centers for Medicare & Medicaid Services, Office of Strategic Operations and Regulatory Affairs, Room N2-17-23, 7500 Security Boulevard, Baltimore, MD 21244-1850, Attn: John Burke CMS-2132-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-2132-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

A. Overall Impact

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 Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), and Executive Order 13132.

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 annually).

We are unable to provide a specific dollar estimate of the economic impact this proposed regulation would have on State and local governments and participating providers. Because the flexibility permitted under Medicaid allows States to provide audiology under various Medicaid benefits, it is not possible to capture accurate expenditure data.

We have determined, however, that this proposed rule is not a major rule under Executive Order 12866, and the Secretary certifies that this proposed rule would not have a significant economic impact on a substantial number of small entities. We have made this determination because while we believe this rule would permit States to have more flexibility in determining who is qualified to provide audiology services, we do not anticipate any increase in States' use of audiology services due to this regulation. Section 804(2) of title 5, United States Code (as added by section 251 of Pub. L. 104–121), specifies that a "major rule" is any rule that the Office of Management and Budget finds is likely to result in—

- An annual effect on the economy of \$100 million or more;
- A major increase in costs or prices for consumers, individual industries, Federal, State, or local government agencies, or geographic regions; or
- Significant adverse effects on competition, employment, investment productivity, innovation, or on the ability of United States-based enterprises in domestic and export markets.

In addition, consistent with the Regulatory Flexibility Act (RFA) (5 U.S.C. 601 through 612), we prepare and

publish an initial regulatory flexibility analysis for proposed regulations unless the Secretary certifies that the regulations would not have a significant impact on a substantial number of small entities. For purposes of the RFA, we do not consider States or individuals to be small entities.

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 in any 1 year. For purposes of the RFA, audiologists that generate total revenues of \$6 million or less in any 1 year are considered to be small entities. The Small Business Administration categorizes small businesses for Audiologists along with physical, occupational, and speech therapists. The total number of providers within this category that have total revenues of between \$5 million and \$7.5 million or less in any one year is 23,823 that they consider small businesses. Those firms and establishments with total revenue above \$7.5 million are not considered small businesses according to the SBA. Therefore, approximately 0.92 percent of audiologist would be considered small businesses. For further information on the SBA size standards see 65 FR 69432. Individuals and States are not included in the definition of a small entity.

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. Such an 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 a Metropolitan Statistical Area and has fewer than 100 beds. This rule will not have a significant impact on small rural hospitals. The Medicaid program permits States the flexibility to provide audiology services under a variety of mandatory and optional benefits. The majority of States do so, mainly as either independent practitioner services, as part of a nursing facility service or community-based clinic services, or as part of their home health or school-based services programs. In addition, current Medicaid rules permit States the flexibility to provide audiology services by, or under the direction of, a qualified audiologist. This provider flexibility is

recognized by states and is widely used to provide audiology services to children through school-based services programs. Because the proposed rule retains the ability for audiology services to be provided "under the direction of," the changes proposed in this rule would not have an impact on how States currently provide services to their Medicaid populations. Therefore, small rural hospitals would not be affected.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule that may result in expenditures in any 1 year by State, local, or tribal governments, in the aggregate, or by the private sector, of \$110 million. We do not anticipate this rule would have an effect on the States, local or tribal governments, or on private sector costs. As we stated earlier, this regulation would give States more flexibility in determining qualified audiologists thereby giving them the ability to choose from a larger provider pool of "qualified" individuals. However, because we expect the primary users of Medicaid audiology services, such as, children and seniors, to remain fairly constant, we do not anticipate any significant increase in the use of audiology services due to this proposed rule. In addition, because Medicaid audiology services are optional for states to provide to their Medicaid populations, many states choosing to do so limit utilization in some manner. In addition, many states limit the use of optional services such as audiology in favor of mandatory Medicaid benefits. States providing audiology services to children under the EPSDT program primarily do so a part of their school-based services program under IDEA. Since all 50 states currently have a school based services program in operation, we do not anticipate this rule to have any significant effect on audiology services provided to Medicaid children. Additionally, recognizing that states currently use the flexibility permitted in the Medicaid law to provide audiology services "under the direction of" a qualified audiologist, we expect states will continue to do so by providing audiology services using individuals working under the supervision of qualified audiologists.

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 a State law, or otherwise has federalism implications.

We do not believe this proposed rule in any way would impose substantial direct compliance costs on State and local governments or preempt or supersede State or local law. This proposed rule would permit States to use State licensed audiologists to provide Medicaid audiology services, thereby giving them increased flexibility in providing Medicaid audiology services. In addition, after researching national audiology usage and reviewing States' currently approved Medicaid States Plans, we anticipate that most, if not all, qualified audiologists currently enrolled in the Medicaid program would continue to be qualified as a result of the continued flexibility proposed in this rule. We also anticipate that States will continue to provide audiology services by using the additional flexibility already granted under the Medicaid program to provide audiology services using individuals meeting State provider qualifications and working within State practice acts "under the direction of" a qualified Medicaid audiologist. We believe the additional flexibility proposed in this rule to recognize State licensure will serve to enhance States ability to provide services. We do not, however, anticipate this rule will have a significant affect on the actual provision of audiology services in State Medicaid programs and therefore does not have Federalism implications.

B. Anticipated Effects

We anticipate this proposed rule will give States increased flexibility in determining who is a Medicaid qualified audiologist. We also anticipate that the quality care standards proposed in this rule would help ensure that Medicaid audiology services continue to be provided by, or under the direction of, highly qualified and trained individuals. Additionally, we believe conforming the Medicare and Medicaid provider requirements would help eliminate any confusion providers may experience in complying with Federal rules and help reduce or eliminate conflict where audiologists provide services to both the Medicaid and Medicare populations (such as in nursing facilities or through home health care agency providers). Additionally, this proposed rule also serves to eliminate inconsistencies in Medicaid provider standards by no longer recognizing equivalency rulings. Under the current Medicaid rules, states can seek equivalency rulings from their State Attorney General in instances where they believe State licensure is equivalent to ASHA certification. Since the proposed rule recognizes State

licensure that meets Medicare-equivalent standards, equivalency rulings are no longer necessary or required. We believe States would look favorably on the elimination of equivalency rulings since they proved administratively burdensome and time-consuming to obtain.

C. Alternatives Considered

In developing the policies set forth in this proposed rule, we met with professional organizations and interested parties to solicit their ideas and concerns. We also worked with our national regional office Staffs to review currently approved Medicaid state plans for information on the provision of audiology services in States' Medicaid programs. We considered the role of audiology services in the Medicaid program and the potential impact changes in the standards for audiology providers would have overall. We considered several options that included (1) no change to the current Medicaid audiology requirements, (2) retain current requirements but issue updated policy guidance on issues such as provider equivalency authority, (3) rewrite the current Medicaid regulations to adopt the current Medicare requirements, and (4) rewrite the current Medicaid regulations to adopt the Medicare standards, but with minimum standards that would apply in States that do not license or that exempt some practitioners from State licensure requirements.

After much research and consideration of the impact of each of the options, we concluded that option 4—the standards proposed in this rule—best satisfy the commitment made by the Secretary and address the request raised by interested parties to conform the definition of a qualified audiologist under the Medicare and Medicaid programs by recognizing the role of state licensure as a Medicaid provider requirement. We also concluded that the standards proposed in this rule best continue to recognize states rights under Medicaid by retaining program flexibility while at the same time also building in quality standards that continue to ensure Medicaid services are provided to all Medicaid-eligible individuals by recognized, highly trained professionals.

D. Conclusion

For the reason stated above, 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 would not have a significant economic impact on a substantial number of small entities or

a significant impact on the operations of a substantial number of small rural hospitals.

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 440

Grant programs—Health, Medicaid.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services would amend 42 CFR chapter IV, part 440 as set forth below:

PART 440—SERVICES: GENERAL PROVISIONS

Subpart A—Definitions

1. The authority citation for part 440 continues to read as follows:

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

2. In § 440.110(c), the introductory text of paragraph (c)(2) is revised, and a new paragraph (c)(3) is added to read as follows:

§ 440.110 Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders.

* * * * *

(c) *Services for individuals with speech, hearing, and language disorders.*

* * * * *

(2) A "speech pathologist" is an individual who—

* * * * *

(3) A "qualified audiologist" means an individual with a master's or doctoral degree in audiology who—(i) Is licensed as an audiologist to perform those services by the State in which the individual furnishes those services, providing that the State licensure requirements meet or exceed those in paragraph (c)(3)(ii)(A) or (c)(3)(ii)(B) of this section;

(ii) In the case of an individual who furnishes audiology services in a State that does not license audiologists, or that exempts audiologists practicing in specific institutions or settings from licensure, the individual must meet one of the following standards:

(A) Have a Certificate of Clinical Competence in Audiology granted by the American Speech-Language-Hearing Association; or

(B) Have successfully completed a minimum of 350 clock-hours of supervised clinical practicum (or is in the process of accumulating that supervised clinical experience under the supervision of a qualified master or doctoral-level audiologist), performed not fewer than 9 months of supervised

full-time audiology services after obtaining a master's or doctoral degree in audiology, or a related field, and successfully completed a national examination in audiology approved by the Secretary.

(iii) Individuals who provide Medicaid audiology services must maintain documentation to demonstrate that they meet the standard(s) set forth in this section.

(Catalog of Federal Domestic Assistance Program No. 93.778, Medical Assistance Program)

Dated: November 26, 2003.

Thomas A Scully,

Administrator, Centers for Medicare & Medicaid Services.

Approved: January 28, 2003.

Tommy G. Thompson,

Secretary.

[FR Doc. 03-8021 Filed 3-31-03; 8:45 am]

BILLING CODE 4120-01-P

FEDERAL MARITIME COMMISSION

46 CFR Part 530

[Docket No. 03-03]

Proposed Amendment to Service Contract Regulations

AGENCY: Federal Maritime Commission.

ACTION: Notice of proposed rulemaking.

SUMMARY: The Federal Maritime Commission proposes to amend its regulations on the electronic filing of service contracts for ocean transportation under the Shipping Act of 1984 ("Shipping Act") (46 U.S.C. app. 1701 *et seq.*), as amended by the Ocean Shipping Reform Act of 1998 ("OSRA"), to add a provision which would permit persons authorized to transmit electronically service contract filings for vessel-operating common carriers, conferences and agreements, to correct within 48 hours an original service contract filing or an amendment that is defective due to electronic transmission errors. The revision would allow a "corrected transmission" of the original service contract or amendment submission to be designated as such and filed in the Commission's electronic service contract filing system, SERVCON.

DATES: Submit comments no later than May 2, 2003. Submit an original and 15 copies of any comments (paper), or e-mail comments as an attachment in WordPerfect 8, Microsoft Word 97, or earlier versions of these applications.

ADDRESSES: Address all comments concerning this proposed rule to: Bryant

L. VanBrakle, Secretary, Federal Maritime Commission, 800 North Capitol Street, NW., Room 1046, Washington, DC 20573-0001, e-mail: secretary@fmc.gov.

FOR FURTHER INFORMATION CONTACT:

Florence A. Carr, Director, Bureau of Trade Analysis, 202-523-5796, e-mail: florence@fmc.gov.

SUPPLEMENTARY INFORMATION: Section 8(c) of the Shipping Act of 1984, as amended by the Ocean Shipping Reform Act of 1998 ("OSRA"), 46 U.S.C. app. 1707(c), and the Commission's current service contract regulations, 46 CFR part 530, subpart A, require service contracts between shippers and ocean common carriers in the foreign commerce of the United States to be filed electronically with the Commission on a confidential basis. Only an "authorized person," as defined in 46 CFR 530.3(c), can access the confidential section of the Commission's electronic service contract filing system, SERVCON, available via the Commission's website. Each individual service contract filer must register with the Commission to obtain a log-on identification and password. Some carriers use individual employees as the authorized person to file their service contracts; however, the majority of carriers authorize third parties to make their service contract filings. The filings may consist of an original service contract or an amendment to an existing service contract. There are currently more than 200 persons registered to transmit service contract filings on behalf of 150 vessel-operating common carriers.

Current regulations provide for the amendment, correction, and cancellation of service contract filings (46 CFR 530.10). The Commission, however, has become aware of a need to provide filers the ability to correct purely electronic "transmission errors" made when filing either the original service contract or an amendment to a service contract into SERVCON, or errors made in the process of converting the service contract filing into electronic format for submission to the SERVCON system. Since the start of SERVCON in May 1999, filers have withdrawn or overwritten these errors.

Under the proposed rule, only errors resulting from electronic transmission and data conversion for SERVCON format may be corrected. Corrections to an initial filing would be allowed within 48 hours from the time and date of receipt recorded in SERVCON (excluding Saturdays, Sundays and legal public holidays). For example, an initial filing received at 5 p.m. on a Friday must be corrected before 5 p.m. the

following Tuesday. The SERVCON system currently has and will continue to have the ability to identify such corrected service contract filings. The Bureau of Trade Analysis will continue to monitor filers' use of the correction process; any abuse of the limited permission in the proposed rule would be considered a violation of the Commission's regulations. Unlike the current regulations which provide for a process to make a retroactive correction in the terms of a filed service contract due to an oversight by the service contract parties,¹ there is no Commission action involved in the process to correct electronic transmission errors that are caused by failures in the hardware or software used by the filers. Therefore, no fee is being proposed for use of this overwrite function in the SERVCON system.

Some examples of filer generated transmission errors that could be corrected under this restricted overwrite proposal are: Incorrect header information, a wrong service contract number, and a wrong file transmitted or uploaded. Examples of substantive service contract changes that would not be allowed under the new proposed 46 CFR 530.10(d) are: Changing rates, deletion of a port or point to be served or a commodity to be carried under the contract; addition or deletion of a shipper entitled to access the service contract, and modification of the duration or minimum quantity commitment of the contract. Instead, these types of changes should continue to be made as "amendments" under 46 CFR 530.10(b) or, if retroactivity is deemed necessary, by filing a request for permission to correct a clerical or administrative error in the terms of a filed service contract under 46 CFR 530.10(c).

Under the proposed rule, the SERVCON system would be modified to accept only corrected service contracts that the filer identifies as such and for which the filer provides a description of the changes being made by the correction process. A new field would be added to the online database as a checkbox for the filer to identify the

¹ Either party to a service contract may request permission to correct a clerical or an administrative error in a filed service contract pursuant to 46 CFR 530.10(c). The request must be submitted within 45 days of the contract's filing and accompanied by a service fee of \$276. Further, a letter of transmittal, affidavit, supporting documentation, and concurrence statement must be included with the request. Upon approval of a request for permission to correct a clerical error, an Order is issued (under delegated authority to the Director, Bureau of Trade Analysis) (see 46 CFR 501.26(n)). The party filing the contract then files an amendment providing for the retroactive correction of the incorrect material.