

Medicare paper billers to fully understand their obligations under ASCA and, in turn, begin preparing for HIPAA implementation, if required to do so. We believe any delay in implementing this rule, effective October 16, 2003, would hinder Medicare providers' ability to meet the October 16, 2003 HIPAA compliance date or determine that they did not have to file electronically with Medicare and so incur unnecessary costs.

Thus, we find, for good cause, that providing notice and opportunity to comment under 5 U.S.C. 553(b) would be impracticable and contrary to the public interest. We are providing a 60-day public comment period.

This rule is effective October 16, 2003, as required by section 3(b) of the ASCA.

V. Collection of Information Requirements

Under the Paperwork Reduction Act (PRA) 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 PRA 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.

Therefore, we are soliciting public comments on each of these issues for the information collection requirements discussed below.

The information collection requirements and associated burdens in § 424.32 are subject to the PRA. The burden of submitting the information required is addressed under OMB approval number:

0938–0866, HIPAA Standards for Coding Electronic Transactions, with a one-time burden of 34,000,000 hours. The current approval expires 5/31/05.

0938–0279, Medicare Uniform Institutional Provider Bill, with an annual burden of 1,666,208 (form CMS–1450). The current approval expires 12/31/05.

0938–0042, Request for Medicare Payment—Ambulance, with an annual

burden of 390,418 hours (form CMS–1491). The current approval expires 3/31/04.

0938–0008, Common Claim form, instructions, and supporting regulations at §§ 414.40, 424.32, and 414.40, with an annual burden of 44,189,007 (form CMS–1500). The current approval expires 3/31/06.

Approximately 205,409 providers and suppliers will be affected by this rule and will have to change the format for the claims they submit (the information collected does not change). They will incur some costs, either that of switching to clearinghouses, which will not affect the time it takes to submit the information for a claim, but will cost them \$.30 per claim, or that of purchasing computer equipment, which we estimate at \$500 to \$1,000.

For our rule published to implement the electronic transactions in general, we estimated that it would take an average of ten hours per entity to switch over to the mandated standard transaction. (The switch could be from paper to electronic or from another electronic format to the standard format.)

For purposes of this discussion, we are estimating that 37.5 percent of the affected providers and suppliers (that is, those not meeting one of the exceptions) already own computers and will not incur capital costs. We are also estimating that 50 percent of the affected providers and suppliers will start using a clearinghouse or billing service, which will not impose any capital costs subject to the PRA. The remaining 12.5 percent (25,676) will buy computers at an average of \$750, for a total capital cost of \$19.3 million.

On the other hand, the providers and suppliers who own or who will buy a computer will require less time to submit claims. Form CMS–1450 takes approximately 9 minutes to submit in hard copy and .5 minutes to submit electronically; form CMS–1500 takes 15 minutes and 1 minute, respectively; form CMS–1491 takes 10 minutes and 1 minute, respectively.

If the 50 percent of the entities that will bill us directly are responsible for 25 percent of the paper bills (we assume that half of the bills are submitted by entities that will be excepted from the requirements, and that 25 percent will be submitted through an intermediate party), they will save 7,651,089 million hours for form 1500, 58,850 hours for form 1491, and 129,196 hours for form 1450. Mailing costs will be reduced by approximately \$.40 per claim on average and the cost of the forms by \$.03 for the form 1450 and form 1500 (the third form is furnished by CMS). We welcome

comments on this aspect of the collection.

We are submitting a copy of the revision to § 424.32 to OMB for its review of the information collection requirements. The revision is not effective until OMB has approved it. If you comment on any of these information collection and record keeping requirements, please mail copies directly to the following: Office of Strategic Operations and Regulatory Affairs, Centers for Medicare and Medicaid Services, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, MD 21244, Attn: Julie Brown, CMS–0008–IFC, and Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503, Attn: Brenda Aguilar, Desk Officer, CMS–0008–IFC.

VI. Regulatory Impact Analysis

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.

For the purpose of this analysis, CMS uses a pre-statute baseline; therefore, all costs and benefits identified in this impact analysis are attributed to this rulemaking. Nevertheless, the ASCA mandates most aspects of this rulemaking. In particular, the ASCA requires Medicare providers to submit claims electronically and stipulates exceptions that will and may be granted. However, CMS did have discretion in setting the conditions for exceptions, and believes that these exceptions reduce the burden relative to the burden that may have been imposed by ASCA without this enabling regulation.

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). This is not a major rule. While additional costs will be imposed on those entities that do not meet any of the exception requirements and which must purchase the capability to