

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,