

### III. Waiver of Proposed Rulemaking

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** to provide a period for public comment before the provisions of a notice take effect in accordance with section 553(b) of the Administrative Procedure Act (APA) (5 U.S.C. 553(b)). However, we can waive the notice and comment procedure if the Secretary finds, for good cause, that a notice and comment process is impracticable, unnecessary or contrary to the public interest, and incorporates a statement of the finding and the reasons therefore in the notice.

We find for good cause that it is unnecessary to undertake notice and comment rulemaking because this notice merely provides technical corrections to the regulations. We are not making substantive changes to our payment methodologies or policies, but rather, are simply implementing correctly the payment methodologies and policies that we previously proposed, received comment on, and subsequently finalized. The public has already had the opportunity to comment on these payment methodologies and policies, and this correction notice is intended solely to ensure that the FY 2008 SNF PPS final rule accurately reflects them. Therefore, we believe that undertaking further notice and comment procedures to incorporate these corrections into the update notice is unnecessary and contrary to the public interest.

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

Dated: November 19, 2007.

**Ann C. Agnew,**

*Executive Secretary to the Department.*

[FR Doc. E7–23219 Filed 11–29–07; 8:45 am]

**BILLING CODE 4120–01–P**

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Centers for Medicare & Medicaid Services

#### 42 CFR Part 455

[CMS–2264–F]

RIN 0938–AO88

### Medicaid Integrity Program; Limitation on Contractor Liability

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

**ACTION:** Final rule.

**SUMMARY:** The Medicaid Integrity Program (the Program) provides that the Secretary promote the integrity of the Medicaid program by entering into contracts with contractors that will review the actions of individuals or entities furnishing items or services (whether fee-for-service, risk, or other basis) for which payment may be made under an approved State plan and/or any waiver of the plan approved under section 1115 of the Social Security Act; audit claims for payment of items or services furnished, or administrative services furnished, under a State plan; identify overpayments of individuals or entities receiving Federal funds; and educate providers of services, managed care entities, beneficiaries, and other individuals with respect to payment integrity and quality of care. This final rule will provide for limitations on a contractor's liability while performing these services under the Program.

The final rule will, to the extent possible, employ the same or comparable standards and other substantive and procedural provisions as are contained in section 1157 (Limitation on Liability) of the Social Security Act.

**DATES:** *Effective Date:* These regulations are effective on December 31, 2007.

**FOR FURTHER INFORMATION CONTACT:** Barbara Rufo, 410–786–5589 or Crystal High, 410–786–8366.

#### **SUPPLEMENTARY INFORMATION:**

##### **I. Background**

###### *A. Current Law*

States and the Federal Government share in the responsibility for safeguarding Medicaid program integrity. States must comply with Federal requirements designed to ensure that Medicaid funds are properly spent (or recovered, when necessary). The Centers for Medicare & Medicaid Services (CMS) is the primary Federal agency responsible for providing oversight of States' activities and facilitating their program integrity efforts.

###### *B. Medicaid Integrity Program*

Section 6034 of the Deficit Reduction Act (DRA) of 2005 (Pub. L. 109–171, enacted on February 8, 2006) amended title XIX of the Social Security Act (the Act), (42 U.S.C. 1396 *et seq.*) by redesignating the old section 1936 as section 1937; and inserting the new section 1936 to combat Medicaid fraud and abuse. For the first time, the Program authorizes the Federal Government to directly identify, recover, and prevent inappropriate Medicaid payments. It will also support

the efforts of the State Medicaid agencies through a combination of oversight and technical assistance.

Although individual States work to ensure the integrity of their respective Medicaid programs, the Program represents CMS' first comprehensive national strategy to detect and prevent Medicaid fraud and abuse. The Program will provide CMS with the ability to more directly ensure the accuracy of Medicaid payments and to deter those who would exploit the program.

The new section 1936 of the Act states that the Secretary shall promote the integrity of the Medicaid program by entering into contracts with eligible entities to carry out the following activities:

1. Review of the actions of individuals or entities furnishing items or services (whether on a fee-for-service, risk or other basis) for which payment may be made under a State plan approved under title XIX (or under any waiver of this plan approved under section 1115 of the Act) to determine whether fraud, waste, and/or abuse has occurred, or is likely to occur, or whether these actions have any potential for resulting in an expenditure of funds under title XIX in a manner that is not intended under the provisions of title XIX.

2. Audit of claims for payment for items or services furnished, or administrative services rendered, under a State plan under title XIX, including cost reports, consulting contracts; and risk contracts under section 1903(m) of the Act.

3. Identification of overpayments to individuals or entities receiving Federal funds under title XIX.

4. Education of providers of services, managed care entities, beneficiaries, and other individuals with respect to payment integrity and quality of care.

Section 1936 of the Act also provides that the Secretary will, by regulation, provide for the limitation of a contractor's liability for actions taken to carry out a contract under the Medicaid Integrity Program.

##### **II. Provisions of the Proposed Regulation and Response to Comments**

###### *Limitations on Contractor Liability*

Section 6034 of the Deficit Reduction Act of 2005 amended title XIX of the Act by establishing, under the new section 1936, the Medicaid Integrity Program to promote the integrity of the Medicaid program by authorizing the Centers for Medicare & Medicaid Services (CMS) (on behalf of the Secretary) to enter into contracts with contractors that will (1) review the actions of individuals or entities

furnishing items or services (whether fee-for-service, risk, or other basis) for which payment may be made under an approved State plan and/or any waiver of the plan approved under section 1115 of the Social Security Act; (2) audit claims for payment of items or services furnished, or administrative services rendered, under a State plan; (3) identify overpayments to individuals or entities receiving Federal funds under title XIX; and (4) educate providers of services, managed care entities, beneficiaries, and other individuals with respect to payment integrity and quality of care. This final rule will set forth limitations on a contractor's liability while performing these services under the Program.

Contractors that perform activities under the Program will be reviewing activities of providers and others seeking Medicaid payment for providing services to Medicaid beneficiaries. In an effort to reduce or eliminate the Program contractors' exposure to possible legal action from entities they review, section 1936 of the Act requires that we, by regulation, limit the Program contractor's liability for actions taken in carrying out its contract. We must establish, to the extent we find appropriate, standards and other substantive and procedural provisions that are the same as, or comparable to, those contained in section 1157 of the Act.

Section 1157 of the Act provides that any organization having a contract (under Title XI, Part B of the Act) with the Secretary, as well as its employees, fiduciaries, and anyone who furnishes professional services to such an organization, is/are protected from civil and criminal liability in performing its duties under the Act or its contract, provided these duties are performed with due care.

In the July 20, 2007 **Federal Register** (72 FR 39766), we published the proposed rule entitled, "Medicaid Integrity Program; Limitation on Contractor Liability," and provided for a 30-day public comment period. We received a total of 1 timely comment from a health care association. The comment questioned the proposed provisions and we responded with further clarification in our response. Brief summaries for each proposed provision, a summary of the public comments we received, and our responses to comments, are set forth below.

#### *General Comments*

*Comment:* A commenter expressed concern that CMS has not provided the health care community or the public

any information about the federal government's discussions on the Program's contractors, termed Medicaid Integrity Contractor's, (MIC) roles, responsibilities, and qualifications. The commenter also stated the MICs may not understand state-specific payment methodologies, resulting in a significant learning curve. The commenter also expressed concern that a lack of public information about the capabilities of the contractors prevents the transparency which all federal government programs should strive to achieve.

*Response:* We appreciate the commenter's concerns regarding information sharing and transparency, as well as the concern that the MICs may face a significant learning curve in developing a knowledge base and experience regarding state-specific practices. To address these concerns, we have been working aggressively with our state and federal partners and stakeholders (State Medicaid Directors, State Program Integrity Directors, Medicaid Fraud Control Unit Directors, the Federal Bureau of Investigation, and HHS' Office of Inspector General) to share information and to obtain their input on our planning efforts. We have also presented information regarding both the Program and MICs at conferences of national and regional associations, including the National Association of State Medicaid Directors and the National Association for Medicaid Program Integrity. To address the MICs' potential learning curve, we have engaged strategic development contractors to help us build upon the tools and expertise we already have. These strategic contractors are assisting by developing state program integrity profiles, and developing audit protocols, methodologies, and standards for the MICs to use. These tools will establish a solid knowledge baseline for the MICs, enabling them to get off to an aggressive, well-informed start. Moreover, we strive to inform the public about our mission and accomplishments, and encourage interested parties to utilize CMS' internet site to learn more about Medicaid program integrity generally at: <http://www.cms.hhs.gov/MCAIDFraudAbuseGenInfo/>, and more specific information about the CMS' Medicaid integrity implementation plan and efforts at: <http://www.cms.hhs.gov/DeficitReductionAct/Downloads/CMIPupdateaugust2007final.pdf>.

#### Section 455.1 Basis and Scope

The proposed rule, in § 455.1, Basis and scope, added a new paragraph (c) stating that subpart C implements section 1936 of the Act. Section 1936 of the Act establishes the Medicaid

Integrity Program under which the Secretary will promote the integrity of the program by entering into contracts with eligible entities to carry out the activities under subpart C. We did not receive public comments on this provision, therefore we adopt the provision as final.

#### *Subpart C—Medicaid Integrity Program*

##### Section 455.200 Basis and Scope

In § 455.200(a), we set forth the proposed statutory basis which would implement section 1936 of the Act, which states that the Secretary will promote the integrity of the Medicaid program by entering into contracts with eligible entities to carry out the activities under subpart C. In § 455.200(b) we proposed the scope for the limitation on a contractor's liability to carry out a contract under the Medicaid Integrity Program as proposed under new § 455.202. We did not receive public comments on this provision; therefore we adopt the provision as final.

##### Section 455.202 Limitation on Contractor Liability

We proposed in § 455.202 to protect Program contractors from liability in the performance of their contracts provided they carry out their contractual duties with due care.

*Comment:* A commenter questioned the proposed standard for the MICs which states they will be protected from civil and criminal liability in performing their duties so long as they perform these duties with "due care." The commenter expressed that under such a standard, the Federal Government cannot sufficiently ensure that the MICs will be held adequately accountable for their actions.

*Response:* As explained in the proposed rule, we believe that the due care standard specified in § 455.202 is the only standard consistent with the statutory mandate of the Act. Section 1936 of the Act require us to limit a contractor's liability by employing the same or comparable standards and provisions as are contained in section 1157 of the Act. Section 1157 of the Act limits a contractor's liability under a due care standard. We believe that applying this standard to the MICs strikes a reasonable balance between the concerns of the contractors and those subject to the contractors' review. We further believe the MICs will operate with due care to avoid liability, and those being reviewed have the assurance that they have legal recourse if a contractor fails to abide by that standard.

### Alternative Standards of Liability Considered

In accordance with section 1936 of the Act, we proposed to employ the same standards for payment of legal expenses as are contained in section 1157(d) of the Act. Therefore, in § 455.202(b) we proposed that we make payment to Program contractors, their members, employees, and anyone who provides legal counsel or services to them, for expenses incurred in the defense of any legal action related to the performance of the Program contract. We also proposed that any and all payment(s) and the amount of each payment(s) if any, will be determined exclusively by us, and conditioned upon (1) the reasonableness of the expense(s); (2) the amount of government funds available for payment(s); and (3) whether the payment(s) is(are) allowable under the terms of the contract.

In § 455.202, we considered employing a standard for the limitation of liability other than the due care standard. We considered whether it would be appropriate to provide that a contractor would not be civilly liable by reason of the performance of any duty, function, or activity under its contract provided the contractor was not grossly negligent in that performance. However, section 1936 of the Act requires that we employ the same or comparable standards and provisions as are contained in section 1157 of the Act. This approach is consistent with a similar approach taken in the Medicare Integrity Program (72 FR 48870), which has virtually identical statutory limitations on contractor liability language. Therefore, we did not believe that it would be appropriate to expand the scope of immunity to a standard of gross negligence, as it would not be a comparable standard to that set forth in section 1157(b) of the Act.

### III. Provisions of the Final Rule

In this final rule we are adopting the provisions as set forth in the July 20, 2007 proposed rule (72 FR 39776) as final.

### IV. 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.

### V. Regulatory Impact Statement

We have examined the impact 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 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 in any 1 year). This rule will not reach the economic threshold and thus is not considered a major rule.

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 small governmental jurisdictions. 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. Individuals and States are not included in the definition of a small entity. We are not preparing an analysis for the RFA because we have determined that this rule will not have a significant economic impact on a substantial number 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 that is located outside of a Metropolitan Statistical Area and has fewer than 100 beds. We are not preparing an analysis for section 1102(b) of the Act because we have determined that this rule will not have a significant impact on the operations of a substantial number of small rural hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of \$100 million in 1995 dollars, updated annually for inflation. That threshold level is currently approximately \$120 million. This rule will have no consequential 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 rule that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. Since this regulation will not impose any costs on State or local governments, the requirements of E.O. 13132 are not applicable.

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 455

Fraud, Grant programs—health, Health facilities, Health professions, Investigations, Medicaid, Reporting and recordkeeping requirements.

■ For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services amends 42 CFR chapter IV as set forth below:

### PART 455—PROGRAM INTEGRITY; MEDICAID

■ 1. The authority citation for part 455 continues to read as follows:

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

■ 2. In § 455.1, add new paragraph (c) to read as follows:

#### § 455.1 Basis and scope.

\* \* \* \* \*

(c) Subpart C implements section 1936 of the Act. It establishes the Medicaid Integrity Program under which the Secretary will promote the integrity of the program by entering into contracts with eligible entities to carry out the activities of subpart C.

■ 3. New subpart C, consisting of § 455.200 and § 455.202, is added to part 455 to read as follows:

#### Subpart C—Medicaid Integrity Program

Sec.

455.200 Basis and scope.

455.202 Limitation on contractor liability.

#### Subpart C—Medicaid Integrity Program

##### § 455.200 Basis and scope.

(a) *Statutory basis.* This subpart implements section 1936 of the Act that establishes the Medicaid Integrity Program under which the Secretary will promote the integrity of the program by entering into contracts with eligible entities to carry out the activities under this subpart C.

(b) *Scope.* This subpart provides for the limitation on a contractor's liability to carry out a contract under the Medicaid Integrity Program.

**§ 455.202 Limitation on contractor liability.**

(a) A program contractor, a person, or an entity employed by, or having a fiduciary relationship with, or who furnishes professional services to a program contractor will not be held to have violated any criminal law and will not be held liable in any civil action, under any law of the United States or of any State (or political subdivision thereof), by reason of the performance of any duty, function, or activity required or authorized under this subpart or under a valid contract entered into under this subpart, provided due care was exercised in that performance and the contractor has a contract with CMS under this subpart.

(b) CMS pays a contractor, a person, or an entity described in paragraph (a) of this section, or anyone who furnishes legal counsel or services to a contractor or person, a sum equal to the reasonable amount of the expenses, as determined by CMS, incurred in connection with the defense of a suit, action, or proceeding, if the following conditions are met:

(1) The suit, action, or proceeding was brought against the contractor, person or entity by a third party and relates to the contractor's, person's or entity's performance of any duty, function, or activity under a contract entered into with CMS under this subpart.

(2) The funds are available.

(3) The expenses are otherwise allowable under the terms of the contract.

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

Dated: September 27, 2007.

**Kerry Weems,**

*Acting Administrator, Centers for Medicare & Medicaid Services.*

Approved: October 9, 2007.

**Michael O. Leavitt,**

*Secretary.*

[FR Doc. E7-23217 Filed 11-29-07; 8:45 am]

**BILLING CODE 4120-01-P**

**DEPARTMENT OF HEALTH AND HUMAN SERVICES****Centers for Medicare & Medicaid Services****42 CFR Part 484**

[CMS-1541-CN2]

RIN 0938-A032

**Medicare Program; Home Health Prospective Payment System Refinement and Rate Update for Calendar Year 2008; Corrections**

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

**ACTION:** Final rule with comment period; correction notice.

**SUMMARY:** This document corrects typographical and technical errors that appeared in the August 29, 2007 *Federal Register*, entitled "Medicare Program; Home Health Prospective Payment System Refinement and Rate Update for Calendar Year 2008."

**EFFECTIVE DATE:** This correction notice is effective January 1, 2008.

**FOR FURTHER INFORMATION CONTACT:** Sharon Ventura, (410) 786-1985.

**SUPPLEMENTARY INFORMATION:****I. Background**

FR Doc. 07-4184 of August 29, 2007 (72 FR 49762) contained several typographical and technical errors that this notice serves to identify and correct.

**II. Summary of Errors**

On page 49773, in the second paragraph of the third column, the reference to the McCall report is incomplete. We are correcting the error by providing the complete reference.

In the first column on page 49774, we are clarifying and correcting an erroneous reference to certain V codes in our response to a comment.

In the first full paragraph of the first column on page 49775, we inadvertently imply that a table is included in the August 29, 2007 final rule. However, the referenced table is found in the May 4, 2007 proposed rule. We are correcting this by referencing the proposed rule.

On page 49780, the example in column 1 is revised to reflect the updates made to Table 2A in the final rule with comment period.

On page 49789, in the fourth column of Table 2B, the Short Descriptions of ICD-9-CM codes 161, 162, 163, 164, and 165 incorrectly contain asterisks.

On page 49793, in Table 2B, the ICD-9-CM code 321.8, we inadvertently did

not include an 'M' next to it under the column titled, "Manifestation codes" in order to properly identify it as a manifestation code.

To more accurately reflect ICD-9-CM coding terminology, we are correcting the Diagnostic Category titles for ICD-9-CM codes V55.0 and V55.5 on page 49817 of Table 2B. In addition we are correcting the Diagnostic Category titles for ICD-9-CM codes V55.5, V55.0, and V55.6 and the Short Descriptions for ICD-9-CM codes V55.5 and V55.0 on page 49855 of Table 10B.

During production of Table 4 on pages 49826 through 49827, the decimal amounts were incorrectly rounded when computing the scaled coefficients. We are revising Table 4 to reflect the corrected rounded amounts.

The average cost amounts in Table 5 on pages 49828 through 49832 were also rounded incorrectly. Therefore, we are revising Table 5 to reflect the average cost of each case-mix group. There are no changes to the relative weights in Table 5.

On page 49833, second paragraph, a negative sign was inadvertently placed before "8.7 percent."

On page 49844, we incorrectly stated the acronym for the Health Insurance Prospective Payment System (HIPPS) code. The correct acronym is HIPPS. We are correcting the acronym to HIPPS wherever it appears.

On page 49853 the description for Item #5 for selected skin conditions in Table 10A incorrectly includes the words "or other". Also on page 49853, in the first column of the Note section for Table 10A, we are correcting punctuation errors. Therefore, in the second column of the Note section for Table 10A, the reference to Table 12B should refer to Table 10B. Lastly, we inadvertently excluded a footnote to Table 10A that clarified how points are awarded for ulcer related conditions.

On page 49854, we are correcting the short description of ICD-9-CM code 250.8x & 707.10-707.9 from "(PRIMARY OR FIRST OTHER DIAGNOSIS = 250.8x AND PRIMARY OR FIRST OTHER DIAGNOSIS = 707.10-707.9)." to "(PRIMARY DIAGNOSIS = 250.8x AND OTHER DIAGNOSIS = 707.10-707.9)."

On page 49855, we inadvertently omitted ICD-9-CM code 948 from Table 10B under the traumatic wounds, burns and post-operative complications category. We are adding code 948 and its short description to Table 10B.

Table 12 and 14 contain several typographical errors. The CY 2007 per-visit amount for the speech-language pathology discipline found in the second column of both Table 12 on page