DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 430, 433, 447, and 457

[CMS–2292–P]

RIN 0938–AQ32

Medicaid and Children's Health Insurance Programs; Disallowance of Claims for FFP and Technical Corrections

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

ACTION: Proposed rule.

SUMMARY: This proposed rule reflects the Centers for Medicare and Medicaid Services' commitment to the general principles of the President's Executive Order 13563 released January 18, 2011, entitled ''Improving Regulation and Regulatory Review,'' as this rule would: implement a new reconsideration process for administrative determinations to disallow claims for Federal financial participation (FFP) under title XIX of the Act (Medicaid); lengthen the time States have to credit the Federal Government for identified but uncollected Medicaid provider overpayments and provide that interest will be due on amounts not credited within that time period; make conforming changes to the Medicaid and Children's Health Insurance Program (CHIP) disallowance process to allow States the option to retain disputed Federal funds through the new administrative reconsideration process; revise installment repayment standards and schedules for States that owe significant amounts; provide that interest charges may accrue during the new administrative reconsideration process if a State chooses to retain the funds during that period. This proposed rule would also make a technical correction to reporting requirements for disproportionate share hospital payments, revise internal delegations of authority to reflect current CMS structure, remove obsolete language, and correct other technical errors.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on September 2, 2011.

ADDRESSES: In commenting, please refer to file code CMS–2292–P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (please choose only one of the ways listed):

1. *Electronically.* You may submit electronic comments on this regulation to *http://www.regulations.gov.* Follow the instructions under the ''More Search Options'' tab.

2. *By regular mail.* You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, *Attention:* CMS–2292–P, P.O. Box 8016, Baltimore, MD 21244–8016 .

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, *Attention:* CMS–2292–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

4. *By hand or courier.* If you prefer, you may deliver (by hand or courier) your written comments before the close of the comment period to either of the following addresses:

a. For delivery in Washington, DC—Centers for Medicare & Medicaid Services, Department of Health and Human Services, Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201.

(Because access to the interior of the Hubert H. Humphrey 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.)

b. For delivery in Baltimore, MD—Centers for Medicare & Medicaid Services, Department of Health and Human Services, 7500 Security Boulevard, Baltimore, MD 21244–1850.

If you intend to deliver your comments to the Baltimore address, please call telephone number (410) 786–7195 in advance to schedule your arrival with one of our staff members.

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

Submission of comments on paperwork requirements. You may submit comments on this document's paperwork requirements by following the instructions at the end of the ''Collection of Information Requirements'' section in this document.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT:

Robert Lane, (410) 786–2015, or Lisa Carroll, (410) 786–2696, for general information.

Edgar Davies, (410) 786–3280, for Overpayments.

Claudia Simonson, (312) 353–2115, for Overpayments resulting from Fraud.

Rory Howe, (410) 786–4878, for Upper Payment Limit and Disproportionate Share Hospital.

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following Web site as soon as possible after they have been received: *http://regulations.gov.* Follow the search instructions on that Web site to view public comments.

Comments received timely will also 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 1–800–743–3951.

I. Background

Title XIX of the Social Security Act (the Act) authorizes Federal grants to States to jointly fund programs that provide medical assistance to low-income families, the elderly, and persons with disabilities. This Federal-State partnership is administered by each State in accordance with an approved State plan. States have considerable flexibility in designing their programs, but must comply with Federal requirements specified in the Medicaid statute, regulations, and interpretive agency guidance. Federal financial participation (FFP) is available for State medical assistance expenditures, and administrative expenditures related to operating the State Medicaid program, that are authorized under Federal law and the approved State plan.

Section 490l of the Balanced Budget Act of 1997 (Pub. L. 105–33, enacted on August 5, 1997) (BBA), added title XXI

to the Social Security Act (the Act) which authorizes the Children's Health Insurance Program (CHIP) to jointly fund State efforts to initiate and expand the provision of child health assistance to uninsured, low-income children. Such assistance is primarily provided by obtaining health benefits coverage through (1) a separate child health program that meets the requirements specified under section 2103 of the Act; (2) expanded eligibility for benefits under the State's Medicaid plan under title XIX of the Act; or (3) a combination of the two approaches. Available Federal funding is limited to an annual allotment. To be eligible for Federal funds under title XXI of the Act, States must submit a State child health plan, which must be approved by the Secretary.

Prior to the passage of the Medicare Improvement for Patients and Providers Act of 2008 (Pub. L. 110–275, enacted on July 15, 2008) (MIPPA) in 2008, the administrative review of Medicaid claims for FFP that CMS has disallowed (disallowances) was governed by section 1116(d) of the Act, which provided simply that States were entitled to a reconsideration of any disallowance. The current regulations, as discussed below, delegated that reconsideration to the HHS Departmental Appeals Board (Board).

Section 2107(e)(2)(B) of the Act makes section 1116 of the Act applicable to CHIP, to the same extent as it is applicable to Medicaid, with respect to administrative review, unless inconsistent with the CHIP statute. As a result, the same basic administrative review process, with reconsideration through the Board process, was made applicable by regulation to CHIP.

In section 204 of the MIPPA, section 1116(d) of the Act was amended to remove Medicaid (and by implication CHIP) from the section 1116(d) process, and a new section 1116(e) of the Act was added to set forth a Medicaid-specific (and by implication CHIP) administrative review process.

This new section 1116(e) of the Act added by MIPPA provides that the State shall be entitled to and, upon request, shall receive a reconsideration of the disallowance, provided that such request is made during the 60-day period that begins on the date the State receives notice of the disallowance. In addition, a State may appeal, in whole or in part, a disallowance by the Secretary, or an unfavorable reconsideration of a disallowance, to the Board by filing a notice of appeal with the Board during the 60-day period that begins on the date the State receives notice of the disallowance or of the unfavorable reconsideration.

The current rules setting forth the process for administrative review for determinations that State claims for Federal funding are not allowable (disallowances) are set out in the Medicaid program at § 430.42 and for the CHIP program at § 457.212. Those rules set out a process for disallowance of FFP and provide for reconsideration of disallowances by the HHS Board using procedures set forth in 45 CFR part 16. The rules provide a framework, which has been used by the Department for resolution of an increasing range of disputes.

Section 6506 of the Patient Protection and Affordable Care Act (Pub. L. 111–148, enacted on March 23, 2010) (the Affordable Care Act) amended section 1903(d)(2) of the Act to extend the period from 60 days to 1 year for which a State may collect an overpayment from providers before having to return the Federal funds. This section also provides for additional time beyond the 1 year for States to recover debts due to fraud when a final judgment (including a final determination on an appeal) is pending.

II. Provisions of the Proposed Rule

This proposed rule would revise regulatory provisions in 42 CFR parts 430, 433, 447, and 457.

A. Administrative Review of Determinations to Disallow Claims for FFP

Section 204 of the MIPPA (Review of Administrative Claim Determination) amended section 1116 of the Act by striking ''title XIX'' from section 1116(d) of the Act and adding section 1116(e) of the Act which provides language that States may obtain review by the Board of an agency decision or reconsidered agency decision. Therefore, we are proposing to revise § 430.42 to set forth new procedures to review administrative determinations to disallow claims for FFP. These new procedures would provide for the availability of an informal agency reconsideration and a formal adjudication by the HHS Board.

Specifically, § 430.42(b) would provide States the option to request administrative reconsideration of an initial determination of a Medicaid disallowance. These revisions identify timeframes for the reconsideration process. The timeframes that we are proposing are short because we view this reconsideration process to be a quick and efficient process for States to point out clear errors or omissions in disallowance determinations, relating either to facts or policy interpretations, that can be corrected before the parties incur further time and expense in an appeal to the Board. Disputes that involve complex fact-finding or issues of legal authority are not appropriate for this expedited review process.

Section 430.42(c) describes the procedures for such a reconsideration, § 430.42(d) describes the option for a State to withdraw a reconsideration request, and § 430.42(e) describes the procedures for issuing reconsideration decisions and implementing such decisions. We propose that neither the State nor CMS will be limited to a record developed in the reconsideration process in any further appeal of the matter. This is consistent with the provisions of section 1116(e)(2)(B) of the Act which provides for the Board to consider ''such documentation as the State may submit and as the Board may require'' including ''all relevant evidence.''

Because section 1116(e)(2)(B) of the Act clarifies that the Board decision (and by implication the reconsideration decision) is to be based on documentation submitted by the State, we include a statement in the proposed regulations reflecting the existing principle that the State is responsible for documenting the allowability of its claims for FFP. Because the Medicaid program is State-administered, the State is in possession of the underlying factual information on its claims, and therefore, has the responsibility of documenting submitted claims. This is not a new principle, and is currently applied by the Board in reviewing disallowance determinations, but it is important to reiterate this point to make clear how the reconsideration and review process will operate.

Section 430.42(f) provides States the option of appeal to the Board of either an initial determination of a Medicaid disallowance, or the reconsideration of such a determination under § 430.42(b). The procedures for such an appeal are set forth in § 430.42(g). For this purpose, we have proposed that the Board shall follow the procedures set forth in its regulations at 45 CFR part 16, but we have included language from section 1116(e)(2)(B) of the Act to describe the scope of the Board review to include ''a thorough review of the issues, taking into account all relevant evidence, including such documentation as the State may submit and as the Board may require.'' In § 430.42(h), we set forth the procedure for issuance and implementation of the final decision.

B. State Option To Retain Federal Funds Pending Administrative Review and Interest Charges on Properly Disallowed Funds Retained by the State

Section 204 of the MIPPA (Review of Administrative Claim Determination) amended section 1116 of the Act by striking ''title XIX'' from section 1116(d) of the Act and adding section 1116(e) of the Act which provides language that the States may obtain review by the Board of an agency decision or reconsidered agency decision. Section 1903(d)(5) of the Act gives a State the option of retaining the amount of Federal payment in controversy when such payment has been disallowed by the Secretary pending a final administrative determination upon review. In other words, the statute provides a State the option of retaining (or returning) the entire amount of Federal payment that has been disallowed, while that disallowance is being reconsidered by the agency, or under appeal to the Board. If a final administrative determination has been made upholding the disallowance, the State must return all disallowed amounts with interest ''for the period beginning on the date such amount was disallowed and ending on the date of such final determination.''

Specifically, we propose to revise § 433.38 to clarify the application of interest when the State opts to retain Federal funds. These regulations specify the procedures that CMS and a State must follow when the State chooses to retain the funds pending a final administrative determination. The current regulations provide that a State that chooses to retain the disallowed funds during an appeal to the Board is required to pay interest on any portion of the disallowance that is ultimately sustained by the Board. Section 433.38 would be revised to add language clarifying that interest would accrue on disallowed claims of FFP during both the reconsideration process and the Board appeal process. We are also providing clarifying language regarding interest charged on disallowed claims during the repayment of Federal funds by installments. If a State chooses to retain the FFP when a claim is disallowed and appeals the disallowance, the interest will continue to accrue through the reconsideration and the Board decision. If the disallowance is upheld, the State may request a repayment of FFP by installments.

We are also proposing two options for the repayment of interest that accrues from the date of the disallowance notice until the final Board decision when a State elects repayment by installments. It has consistently been our policy that once the State has exhausted all of its administrative appeal rights and the disallowance has been upheld, the principal overpayment amount plus interest through the date of final determination becomes the new overpayment amount. We are proposing to provide States with an additional option for repaying that interest during a repayment schedule. Given States' current fiscal situation, we believe that allowing some flexibility in the repayment of interest during the repayment schedule may further assist States with their budgetary concerns.

If a State chooses to repay the overpayment by installments, the State may choose the option of:

(1) Dividing the new overpayment amount (principal plus initial interest) by the 12-quarters of repayment. The initial interest is interest from the date of the disallowance notice until the first payment. The State will still be required to pay interest per quarter on the remaining balance of the overpayment until the final payment. To clarify how this option would work, we provide an example in Table 3; or

(2) Paying the first installment of the principal plus all interest accrued from the date of the disallowance notice through the first payment. The first installment would include the principal payment plus interest calculated from the date of the disallowance notice. Each subsequent payment would include the principal payment plus interest calculated on the remaining balance of the overpayment amount.

Under section 1903(d)(5) of the Act, a State that wishes to retain the Federal share of a disallowed amount will be charged interest, based on the average of the bond equivalent of the weekly 90-day treasury bill auction rates, from the date of the disallowance to the date of a final determination.

A State that has given a timely written notice of its intent to repay by installments to CMS will accrue interest during the repayment schedule on a quarterly basis at the Treasury Current Value Fund Rate (CVFR), from:

(1) The date of the disallowance notice, if the State requests a repayment schedule during the 60-day review period and does not request reconsideration by CMS or appeal to the Board within the 60-day review period.

(2) The date of the final determination of the administrative reconsideration, if the State requests a repayment schedule during the 60-day review period following the CMS final determination and does not appeal to the Board.

(3) The date of the final determination by the Board, if the State requests a repayment schedule during the 60-day review period following the Board's final determination.

The initial installment will be due by the last day of the quarter in which the State requests the repayment schedule. If the request is made during the last 30 days of the quarter, the initial installment will be due by the last day of the following quarter. Subsequent repayment amounts plus interest will be due by the last day of each subsequent quarter.

The CVFR is based on the Treasury Tax and Loan (TT&L) rate and is published annually in the **Federal Register**, usually by October 31st (effective on the first day of the next calendar year), at the following Web site: *http://www.fms.treas.gov/cvfr/index.html*.

We are soliciting comments related to these approaches and the best application of interest when a State chooses repayment of FFP by installments. We are also interested in any suggestions on alternative approaches with respect to the repayment of interest during the repayment schedule.

C. Repayment of Federal Funds by Installments

Currently, § 430.48 provides that States with significant repayment obligations in proportion to the size of their Medicaid programs may repay that liability in installments. Current regulations provide a 12-quarter time period for repayment similar to the time period implemented by the Federal Claims Collection Act. The State must meet two basic conditions for a repayment of Federal funds by installment. The amount to be repaid must exceed 2.5 percent of the estimated or actual annual State share of the Medicaid program and the State must provide written notice of intent to repay by installments before the total repayment is due.

Currently, the number of quarters allowed for a repayment schedule is determined on the basis of the ratio of repayment amounts to the annual State share of Medicaid expenditures. The percentages of the annual State amounts used to determine the proposed amounts of quarterly installments are: 2½; percent for each of the first 4 quarters; 5 percent for each of the second 4 quarters; and 17½; percent for each of the last 4 quarters.

This proposed rule would amend § 430.48 to revise the repayment schedule, providing more options for States electing a repayment schedule for

the payment of Federal funds by installment. We are proposing three schedules including schedules that recognize the unique fiscal pressures of States that are experiencing economic distress, and to make technical corrections.

The rationale for the installment repayment schedule is to enable States to continue to operate their programs effectively while repaying the Federal share. HHS has determined that the current provision is not sufficiently flexible to meet that goal. Therefore, we are revising the general provision to provide States with additional options for repayment.

Current regulations provide an exception to the 12-quarter time period for repayment when amounts due exceed the State's share of annual expenditures for the program to which the disallowance applies. We are not proposing to amend this provision.

We are proposing to replace the existing repayment schedule and qualifying criteria for States with significant repayment obligations (repayment amounts of at least 2.5 percent of total annual Medicaid expenditures) with three new repayment options to assist States in repayment of Federal funds. Two of the options are available to States at the time that the disallowance is established, either at the issuance of a disallowance letter or issuance of the administrative appeal decision.

The first option is a new standard repayment schedule. Any State would have the option of electing this standard repayment schedule which would allow the State to repay on a quarterly basis over a 3-year period, subject to a minimum repayment amount of at least 0.25 percent of total annual State share of Medicaid expenditures.

The second new option would be available to States experiencing a period of economic distress as defined in this proposed regulation. This option would also allow States to return funds over a 3-year period; however, States would have smaller payments in the first 2 years when their fiscal circumstances are more difficult and larger payments in the final year to ensure payment in full.

The third option is available for States who experience a period of economic distress that occurs or continues during an existing repayment plan. This third option allows the State an additional period of time to repay owed amounts dependent upon the ongoing economic health of the State. We describe each new option in this section. Furthermore, to clarify how the various proposed revised standard and alternative repayment schedules would work, we provide an example in Table 1.

1. Standard Repayment Schedule

In § 430.48, we propose to replace the current 2.5 percent threshold for determining whether a State would qualify for a repayment schedule. Therefore, all States that meet the new proposed 0.25 percent threshold would be eligible to choose the new standard repayment schedule (option 1). We propose a quarterly repayment schedule in which the State would repay the total overpayment amount in no more than a 12-quarter period (3 years). The amounts of the quarterly installments and the total quarters of the repayment schedule will be determined by dividing the total overpayment amount by a minimum proposed amount of quarterly installments. In this repayment schedule, the State must pay at least a minimum repayment amount per quarter of 0.25 percent of the annual State share (plus any calculated interest). The State would be required to repay not less than this amount each quarter for up to a 12-quarter period. The total repayment amount must be fully repaid within the 12-quarter period. In many instances, due to the minimum quarterly payment requirement, the repayment amount will be paid in full in less than 12 quarters.

Except in times when economic distress occurs during an existing repayment plan (option 3), as described below, the standard repayment period may not exceed 12 quarters unless the total repayment amount exceeds 100 percent of the State's estimated State share of annual expenditures.

Current regulations require that the remaining amount of the repayment be in quarterly amounts equal to not less than 17.5 percent of the estimated State share of annual expenditures. If the total repayment amount exceeds 100 percent of the State's estimated State share of annual expenditures, we are proposing a change that would allow the remaining amount of the repayment to be in quarterly amounts equal to not less than 8⅓ percent of the overpayment amount. This change would allow for repayment of the total amount that exceeds 100 percent of the State's estimated State share of annual expenditures to be repaid in 12 quarters.

The proposed 12-quarter time period for repayment is similar to the time period implemented in the Federal Claims Collection Act (Pub. L. 89–508), which generally limits the repayment of a debt due the Federal Government to 3 years. The Department's implementing regulations at 45 CFR 30.17, provide that the size and frequency of the payments should reasonably relate to the size of the debt and the debtor's ability to pay. Additionally, the installment agreement will provide for full payment of the debt, including interest and charges, in 3 years or less, when feasible. We believe that the proposed 12-quarter standard timeframe for repayment aligns with the intent of the Federal Claims Collection Act and implementing regulations. We are interested in comments related to the use of a minimum quarterly repayment amount allowing up to a 12-quarter repayment timeline.

We have also proposed to eliminate the requirement for offsetting of retroactive claims. This provision would undermine the purpose of the revised repayment schedule. Offsetting currently requires that prior period increasing adjustments claimed by States that are over 1-year old would be applied against the repayment amount. This would have the effect of altering (shortening) the repayment schedule by the amount of prior period claims for unrelated expenditures.

We are soliciting comments on the modifications to the standardized repayment schedule. We are particularly interested in receiving comments on our use of 0.25 percent of the State share as a minimum required repayment amount.

2. Alternate Repayment Schedule During Periods of Economic Distress

States owing the Federal Government significant amounts of Federal funds during a period of State economic downturn have requested recognition of the realities of their fiscal constraints through more flexibility in repayment by installment plan. We share the concern of States with respect to repayment of Federal funds during periods of State economic distress. We realize that immediate repayment of the entire amount or even repayment by installments under the new proposed regulations in certain instances could result in hardship for the health programs being administered by the State and have an adverse effect on the beneficiaries of these programs. Therefore, we are proposing an option (option 2) for States that have been experiencing economic distress. This option is an alternate to the standard repayment schedule for States experiencing economic distress at the time that a repayment schedule is initially developed. We are seeking comments not only on the creation of an alternate repayment schedule but also on all elements of the alternate schedule.

We are proposing at § 430.48(d) that if a State has been experiencing periods of economic distress, defined as a negative percentage change in the State's coincident index as determined by the Philadelphia Federal Reserve Bank, within the 6 months immediately prior to the start of a repayment schedule, the State may elect this alternate repayment schedule instead of the proposed standard repayment schedule. It still provides States up to 12 quarters to repay the full amount, but allows for lower payments in the earlier quarters to provide relief to States beginning to repay Federal funds in a time of economic hardship for the State. The entire overpayment amount will be repaid at the end of the 12-quarter period unless the State qualifies for an extension as discussed in option 3.

In § 430.48(c)(3),we propose that quarterly required repayment amounts will depend upon the total amount owed. If the total amount owed divided by 12 is less than 0.25 percent of the State share, the State would make 12 equal quarterly payments of the lesser amount. If the amount divided by 12 is greater than 0.25 percent of the State share, the quarterly repayment amount for the first 8 quarters will not be more than 0.25 percent of the estimated annual State share plus interest. The remaining balance of the overpayment amount would be divided equally over the remaining 4 quarters. This 12-quarter time period for repayment during periods of State economic distress was used because it is in accordance with the time period implemented by the Federal Claims Collection Act. The Federal Claims Collection Act generally limits the repayment of a debt due the Federal Government to 3 years.

3. Extended Repayment Schedule During Periods of Economic Distress

Additionally, we are proposing at § 430.48(e), an option (option 3) to extend a repayment schedule if a State has entered into a standard repayment schedule or the alternative schedule described above and enters into or continues to experience a period of economic distress. The State may only request to enter into the economic distress extension plan once per repayment; a State may not repeatedly request to begin new repayment periods based on the status of its economic health. This extension would create a new repayment period, beginning the quarter directly following a State's request (for example, 9th quarter), for the outstanding balance of the repayment amount calculated for the remaining quarters and any additional extension quarters.

We are proposing that a State which is already repaying amounts using the standard repayment schedule may request a new 3-year extension period for economic distress. A State that is currently repaying funds under a standard repayment schedule may request an economic distress extension if at any time during the repayment period, the State experiences 6 consecutive months of economic distress.

We are proposing to define ''economic distress'' as a negative percentage change in the State's coincident index as determined by the Philadelphia Federal Reserve Bank. As we discuss below, this index is based on four different State-level indicators that together reflect each State's overall economic health.

The consecutive period that forms the basis for such a request can include months immediately prior to the start of the standard repayment schedule as long as they create a consecutive 6-month period reaching into the repayment period. For example, when determining the initial repayment schedule, a State cannot qualify for the alternative payment schedule (option 2) because it has only experienced 4 consecutive months of economic distress. If the State continues to experience economic distress during the first 2 months of its standard repayment plan, it may request an economic distress extension because it has experienced 6 consecutive months of economic distress, 4 months prior to the repayment schedule and 2 months during the first months of the repayment schedule.

For States in a standard repayment schedule that qualify for the economic distress extension, the outstanding balance, including interest, will be used to recalculate a new 12-quarter repayment schedule using the same methodology as in option 2, the alternate repayment schedule; the remaining balance, including interest will be divided by 12. The first 8 quarterly payments will be the lesser of the quotient or 0.25 percent of the estimated annual State share. As in option 2, the remainder owed will be divided over the final 4 quarters of the extension period. Interest will continue to accrue during the new 12-quarters repayment schedule at the CVFR.

For States initially beginning repayment through an alternate repayment schedule, we propose to allow an extension of the repayment period to provide additional time to repay the overpayment amount if the State continues to find itself in economic distress during the original repayment period. If a State initially has an alternate repayment schedule in place (because it was in economic distress before the repayment schedule began) and has any qualifying periods of economic distress during the first 8 quarters of the alternate repayment schedule, the State may request that we extend the alternate repayment period by the number of such qualifying quarters. For purposes of this additional relief, qualifying periods of economic distress would include those quarters in which the State experienced at least 1 month of economic distress. In other words, for at least 1 month in that quarter, the State experienced economic distress as defined below.

This extension, beyond the original 12 quarters, would extend the number of quarters of qualifying periods of economic distress by the number of quarters in which the State experiences economic distress. We are proposing that the extension would allow a State to recalculate their payment amounts before the increased (ballooned payments) became due and would allow for no more than 8 additional quarters. For example, a State experiencing economic distress for 3 quarters of the first 8 quarters would receive an extension of 3 additional quarters for a total of 15 quarters to fully repay funds owed.

Continuing the example above, the State qualifying for 15 quarters would pay 0.25 percent of the State share for the first 8 quarters. For the remaining 7 quarters, the State would pay the balance of the repayment amount divided by 7 (the number of remaining quarters).

In Table 2, we provide an example to demonstrate and compare a State that repays using the current repayment schedule, the proposed standard repayment schedule, the proposed alternate repayment schedule begun during a period of economic distress, the proposed standard repayment schedule with an economic distress extension, and the proposed alternate repayment schedule initiated in a period of economic distress and extended for continued economic distress. For simplicity and clarity, Table 2 does not include interest that would be charged during the repayment process, but we have provided Table 3 to illustrate the application of interest charges.

TABLE 1—EXAMPLE

Total FY Medicaid State Share	$3,500,000,000
Overpayment Amount	220,200,000
Current Minimum Payment—2.5% of State Share	87,500,000
Proposed Standard Minimum Payment: Higher of:	
0.25% of State Share OR	8,750,000
Disallowed amount (D/A)/12 qtrs	18,350,000
Alternate Economic Distress:	
0.25% of State Share—8 qtrs	8,750,000
D/A balance/4 qtrs	37,550,000
D/A balance/7 qtrs	21,457,143

TABLE 2—EXAMPLE

Quarters	Current repayment schedule	Proposed standard payment schedule	Proposed alternate repayment schedule (State begins in economic distress amount) (no continuing distress)	Proposed alternate repayment schedule (State begins in economic distress) requests and qualifies for economic distress extension for Qtrs 1, 2, and 6)	Proposed alternate repayment schedule (State begins with standard repayment schedule, requests and qualifies for economic distress extension in Qtr. 4)
1	87,500,000	18,350,000	8,750,000	8,750,000	18,350,000
2	87,500,000	18,350,000	8,750,000	8,750,000	18,350,000
3	45,200,000	18,350,000	8,750,000	8,750,000	18,350,000
4		18,350,000	8,750,000	8,750,000	18,350,000
5		18,350,000	8,750,000	8,750,000	8,750,000
6		18,350,000	8,750,000	8,750,000	8,750,000
7		18,350,000	8,750,000	8,750,000	8,750,000
8		18,350,000	8,750,000	8,750,000	8,750,000
9		18,350,000	37,550,000	21,457,143	8,750,000
10		18,350,000	37,550,000	21,457,143	8,750,000
11		18,350,000	37,550,000	21,457,143	8,750,000
12		18,350,000	37,550,000	21,457,143	8,750,000
13				21,457,143	19,200,000
14				21,457,143	19,200,000
15				21,457,142	19,200,000
16					19,200,000
17					
18					
19					
20					
Total Repaid	220,200,000	220,200,000	220,200,000	220,200,000	220,200,000

TABLE 3—EXAMPLE

Principal Overpayment	220,000,000	
Interest	200,000	
Total Overpayment	220,200,000	
Current Value Fund Rate	3%	

Quarters	Proposed standard payment schedule principal	Proposed standard payment schedule interest	Proposed standard payment schedule total
1	18,350,000	1,628,877	19,978,877
2	18,350,000	1,481,088	19,831,088
3	18,350,000	1,348,113	19,698,113
4	18,350,000	1,198,682	19,548,682
5	18,350,000	1,026,191	19,376,191
6	18,350,000	889,932	19,239,932
7	18,350,000	750,389	19,100,389
8	18,350,000	600,958	18,950,958
9	18,350,000	441,603	18,791,603
10	18,350,000	298,776	18,648,776
11	18,350,000	152,665	18,502,665
12	18,350,000	3,234	18,353,234
13			
14			
15			
16			

Quarters	Proposed standard payment schedule principal	Proposed standard payment schedule interest	Proposed standard payment schedule total
17			
18			
19			
20			
Total Repaid	220,200,000	9,820,508	230,020,508

We are proposing that the determination of economic distress would be made on a State-specific basis as opposed to a national index. We believe this will ensure that States experiencing economic difficulty may avail themselves of this option regardless of whether the nation as a whole is facing a recession or time of growth. We believe that it is an equitable way of handling situations in which individual States are experiencing severe fiscal hardship.

We reviewed several different data sources to develop qualifying criteria for States seeking an alternate repayment schedule due to economic distress. We looked for indicators which were readily available to the States and CMS, transparent to the public, robust in its measurement of economic health, based on the most recent data possible, consistent across States, and predictably available on a regular basis in a timely manner. We also attempted to find a measure that mirrored as closely as possible the criteria used by the National Bureau of Economic Research (NBER) to determine a national recession.

We researched several potential economic distress measures and consulted various entities including the National Association of State Budget Officers, the Rockefeller Institute, the Philadelphia Federal Reserve Bank, and the Government Accountability Office (GAO). The main options we considered were a model used by the GAO, the Philadelphia Federal Reserve Bank State coincident index, and the measure of whether a State qualifies for extended benefits in the Unemployment Insurance program overseen by the U.S. Department of Labor. The GAO index is used to provide information to Congress on State level economic health. It provided much of what we believed would be necessary to accurately measure overall economic health. However, it is not publicly available nor is it replicated on a predictable basis. The Unemployment Insurance program provided data that was timely, accurate, and publicly available. However, it did not appear to be the most robust measure of total economic health in a State, nor did it closely reflect the type of information used by the NBER.

We are proposing to adopt the State coincident index as determined by the Philadelphia Federal Reserve Bank. Unlike the other indicators we reviewed, this measure met all of the criteria we established. It is publicly available on the Philadelphia Federal Reserve Web site (www.philadelphiafed.org), based on recent data, published in a timely manner, and published monthly. The index represents a robust measure of economic health. In addition, the Philadelphia Federal Reserve Bank State coincident index data compilation best approximated the type of information NBER reviews in determining a national recession. We are inviting comments on this choice of measures.

The coincident index combines four State-level indicators to summarize current economic conditions in a single statistic: nonfarm payroll employment; average hours worked in manufacturing; the unemployment rate; and wage and salary disbursements deflated by the consumer price index (U.S. city average). The trend for each State's index is set to the trend of its gross domestic product (GDP), so long-term growth in the State's index matches long-term growth in its GDP. The model and the input variables are consistent across the 50 States, so the State indexes are comparable to one another.

We are proposing that a State (including the District of Columbia and the territories) would be eligible to utilize the economic distress option for repayment if the State had a period of continuous distress as demonstrated by negative percent changes in the Philadelphia Federal Reserve Bank State coincident index for the immediate prior 6 months for which data is available. That is, if the State's index were negative for each of the 6 months preceding the beginning of the repayment period, then the State would be deemed to be experiencing a period of economic distress for purposes of the repayment schedule options and could request the alternative repayment schedule.

We performed an analysis to determine how frequently States would qualify for an alternate repayment schedule using the 6-month period as a trigger. Using data from NBER, we identified when the last 4 recession periods occurred and their duration. The most recent NBER declared national recession started in December of 2007 and continued through June 2009. The previous recession was from March 2001 through November 2001. Our objective was to compare the measures and to determine if any State would qualify for an alternate repayment schedule when the nation is not in a recession.

We then turned to data from the Philadelphia Federal Reserve Bank State coincident indexes to determine negative growth by State for the period of January 2005 through May 2010. We found that one State would have qualified for an alternate repayment schedule as early as October 2005 for a 2-month period (for example, for each of those 2 months, the immediate previous 6 months demonstrated economic distress). Additionally, we found other States that qualified as early as November 2007 and some that would qualify as late as April 2010. We only found one State that would not have met the requirements to qualify for the alternate repayment schedule.

We are particularly interested in receiving input on the Philadelphia Federal Reserve State coincident index as the criteria for State economic health. We are soliciting comments on our use of this index as well as suggestions for other potential measures of State economic health and/or distress. We welcome comments on the GAO model and the Unemployment Insurance determination as well as other potential indicators that are not specifically discussed.

We are also soliciting comments on whether the correct measure, if using the Philadelphia Federal Reserve Bank State coincident index, is a negative percent change for each of the previous 6 months in the immediate prior 6-month period. We considered using a 3-month look back period, as well as to look only at the current months within

a given quarter. We encourage comments on this as well as suggestions for alternate measures.

D. Refunding of Federal Share of Overpayments to Providers

We are proposing to revise § 433.300 through § 433.322 in accordance with section 6506 of the Patient Protection and Affordable Care Act (Pub. L. 111–148, enacted on March 23, 2010) (the Affordable Care Act). These provisions amended section 1903(d)(2) of the Act to provide an extension of the period for collection of provider overpayments. Under the new provisions, States have up to 1 year from the date of discovery of an overpayment made to a Medicaid provider to recover or to attempt to recover such an overpayment. At the end of the 1 year period, the State is required to return to the Federal Government the Federal share of any unrecovered amount.

In addition, for overpayments due to fraud, when a State is unable to recover the overpayment (or any portion thereof) within 1 year of discovery because no final determination of the amount of the overpayment has been made under an administrative or judicial process (as applicable), including as a result of a judgment being under appeal, the State will have until 30 days after the date on which a final judgment (including, if applicable, a final determination on an appeal) is made in the judicial or administrative process to recover such overpayment before being required to make the adjustment to the Federal share. Previously, States had up to 60 days to recover an overpayment and make an adjustment to the Federal share. There was also no specific statutory basis set forth in the Act for a State to recover or seek to recover an overpayment made to a Medicaid provider due to fraud. This rule replaces ''60-calendar day'' and ''60-day'' in § 433.316 with ''1-year'' to bring the regulatory language into alignment with the provisions of the Affordable Care Act.

We are also proposing to amend the Departmental regulations at § 433.304 by adding language that defines what constitutes ''final written notice''; when a Medicaid agency may treat an overpayment made to a Medicaid provider as resulting from fraud under § 433.316(d); and that the State is not required to return the Federal share of overpayments until 30 days after a final judgment (including a final determination on appeal) when a State has not recovered an overpayment resulting from fraud within 1-year of discovery. The proposed rule would also amend the regulations by deleting the definition of ''abuse'' from § 433.304 so that the regulatory language mirrors that of the statute as amended by the Affordable Care Act.

We are also proposing that interest will be due by the State on amounts of Medicaid provider overpayments that are not timely refunded by the State. A State that fails to timely refund such amounts improperly retains the use of such funds and will be presumed to have earned interest on that use. Such imputed interest will be deemed program income and must be refunded along with the principal amount. Interest will be assessed at the Current Value of Funds Rate (CVFR) and will accrue beginning on the day after the end of the 1-year period following discovery until the last day of the quarter for which the State submits a CMS–64 report refunding the Federal share of the overpayment.

These regulations do not apply to overpayments involving administrative costs. Therefore, the Federal share of all overpayments involving administrative costs must be refunded immediately following discovery, as required by section 1903(d)(2)(A) of the Act. An example of administrative costs would include any item claimed on the CMS–64.10 forms.

E. Technical Corrections to Medicaid Regulations

1. Grants Procedures

The proposed rule updates references at § 430.30 by striking ''CMS–25'' and adding ''CMS–37.'' The CMS–25 was renamed to the CMS–37, but the changes were never codified in regulation. We took the opportunity in this proposed rule to make the correction. States are currently using the CMS–37 form.

2. Deferral of Claims for FFP

The proposed rule would revise the delegation of authority for deferral determinations under § 430.40 to reflect internal agency organizational changes. Authority to impose deferral of claims for FFP has been revised from the Regional Administrator to the Consortium Administrator responsible for the Medicaid program.

3. Inpatient Services: Application of Upper Payment Limits (UPLs)

The rule proposes technical changes that remove UPL transition period language at § 447.272 and § 447.321. The last transition period expired on September 30, 2008.

4. Reporting Requirements for Disproportionate Share Hospital Payments

The proposed rule would correct a technical error in the regulation text at § 447.299(c)(15). This paragraph provides a narrative description of how ''total uninsured IP/OP uncompensated care costs'' is to be calculated from component data elements. The first sentence unintentionally and incorrectly references costs associated with Medicaid eligible individuals in the description of uninsured uncompensated costs. This reference is incorrect and could not be interpreted reasonably to contribute to an accurate description of ''total uninsured IP/OP uncompensated care costs.'' Additionally, it erroneously contradicts section 1923(g) of the Act, § 447.299, 42 CFR part 455 subpart D, and longstanding CMS policy. The second sentence of § 447.299(c)(15) accurately identifies the component data elements and correctly describes the calculation of ''total uninsured IP/OP uncompensated care costs,'' which does not include Medicaid eligible individuals.

F. Conforming Changes to CHIP Regulations

The CHIP regulations at § 457.210 through § 457.212 and 457.218 mirror Medicaid regulations at 42 CFR parts 430 and 433 related to deferrals, disallowances, and repayment of Federal funds by installments. We are proposing to make conforming changes to both the Medicaid and CHIP programs by striking § 457.210 through § 457.212 and § 457.218 and incorporating the requirements of 42 CFR part 430. We are incorporating these through reference in § 457.628(a).

We are also incorporating the requirements of 42 CFR part 433 with respect to overpayments. Section 2105(c)(6)(B) of the Act incorporates the overpayment requirements of section 1903(d)(2) of the Act into CHIP. Therefore, we are also amending the CHIP regulations to reflect the overpayment requirements as revised by the Affordable Care Act. We are incorporating these through reference in § 457.628(a).

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 following sections of this document that contain information collection requirements:

A. ICRs Regarding Disallowance of Claims for FFP (§ 430.42)

Section 430.42 was revised in accordance with the Medicare Improvement for Patients and Providers Act of 2008 (MIPPA) to set forth new procedures to review administrative determinations to disallow claims for FFP. These new procedures provide for an informal agency reconsideration that must be submitted in writing to the Administrator within 60 day after receipt of a disallowance letter. The reconsideration request must specify the findings or issues with which the State disagrees and the reason for the disagreement. It also may include supporting documentary evidence that the State wishes the Administrator to consider.

The burden associated with this requirement is the time and effort necessary for the State Medicaid Agency to draft and submit the reconsideration letter and supporting documentation. Although this requirement is subject to the PRA, we believe that 5 CFR 1320.4(a)(2), exempts the reconsideration letter as a collection of information and the PRA. In this case, the information associated with the reconsideration would be collected subsequent to an administrative action, that is, a determination to disallow.

B. ICRs Regarding Refund of Federal Share of Medicaid Overpayments to Providers (§ 433.322)

Section 2105(c)(6)(B) of the Act incorporates the overpayment requirements of section 1903(d)(2) of the Act into CHIP. The overpayment regulations at § 433.322 require that the Medicaid Agency ''maintain a separate record of all overpayment activities for each provider in a manner that satisfies the retention and access requirements of 45 CFR 74.53.'' We are incorporating these through reference in § 457.628(a). Accordingly, it would require CHIP programs to comply with § 433.322. States are currently required to maintain these records under current regulations for Medicaid (and by implication CHIP).

The recordkeeping requirements set out under 45 CFR 92.42 (and § 433.322) are adopted from OMB Circular A–110.

C. ICRs Regarding Medicaid Program Budget Report (CMS–37)

The information collection requirements associated with CMS–37 are approved by OMB and have been assigned OMB control number 0938–0101. This proposed rule would not impose any new or revised reporting or recordkeeping requirements concerning CMS–37.

D. ICRs Regarding Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (CMS–64)

The information collection requirements associated with CMS–64 are approved by OMB and have been assigned OMB control number 0938–0067. This proposed rule would not impose any new or revised reporting or recordkeeping requirements concerning CMS–64.

If you comment on these information collection and recordkeeping requirements, please do either of the following:

1. Submit your comments electronically as specified in the **ADDRESSES** section of this proposed rule; or

2. Submit your comments to the Office of Information and Regulatory Affairs, Office of Management and Budget,

Attention: CMS Desk Officer, 2292–P
Fax: (202) 395–6974; or
E-mail: *OIRA_submission@omb.eop.gov.*

IV. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, 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, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

V. Regulatory Impact Statement

A. Statement of Need

This proposed rule: (1) Implements changes to section 1116 of the Act as set forth in section 204 of the Medicare Improvement for Patients and Providers Act of 2008 (Pub. L. 110–275, enacted on July 15, 2008) to provide a new reconsideration process for administrative determinations to disallow claims for Federal financial participation (FFP) under title XIX of the Act (Medicaid);

(2) Implements changes to section 1903(d) (2) of the Act as set forth in section 6506 of the Patient Protection and Affordable Care Act (Pub. L. 111–148, enacted on March 23, 2010) (the Affordable Care Act), to lengthen the time States have to credit the Federal Government for identified but uncollected Medicaid provider overpayments and provides that interest is due for amounts not timely credited within that time period;

(3) Implements changes as set forth in Section 2107(e)(2)(B) of the Act which makes section 1116 of the Act applicable to CHIP, to the same extent as it is applicable to Medicaid, with respect to administrative review, unless inconsistent with the CHIP statute.

(4) Implements changes as set forth by HHS to enable States to continue to operate their Medicaid programs effectively while repaying the Federal share of unallowable expenditures and to provide more flexibility for States to manage their budgets during periods of economic downturn.

(5) Implements changes as set forth by HHS to clarify that interest charges accrue during the new administrative reconsideration process as set forth in section 204 of the Medicare Improvement for Patients and Providers Act of 2008 (Pub. L. 110–275, enacted on July 15, 2008) if a State chooses to retain the funds during that period.

We conducted a review of existing regulations to correct a technical error in the regulation text at § 447.299(c)(15) which erroneously contradicts section 1923(g) of the Act, § 447.299, 42 CFR part 455 subpart D, and longstanding CMS policy; revise internal delegations of authority to reflect current CMS structure; remove obsolete language; and correct other technical errors in accordance with section 6 of Executive Order 13563 of January 18, 2011.

B. Overall Impact

We have examined the impact of this rule as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), Executive Order 13563 on Improving Regulation and Regulatory Review (February 2, 2011), section 1102(b) of the Social Security Act,

section 202 of the Unfunded Mandates Reform Act of 1995 (March 22, 1995; Pub. L. 104–4), Executive Order 13132 on Federalism (August 4, 1999) and the Congressional Review Act (5 U.S.C. 804(2)).

Executive Orders 12866 and 13563 direct 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 does 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 entities, if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Most physician practices, hospitals and other providers are small entities, either by nonprofit status or by qualifying as small businesses under the Small Business Administration's size standards (revenues of less than $7.0 to $34.5 million in any 1 year). States and individuals are not included in the definition of a small entity. For details, see the Small Business Administration's Web site at *http://www.sba.gov/sites/default/files/Size_Standards_Table.pdf.*

We are not preparing an analysis for the RFA because the Secretary has determined that this proposed rule would 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 RIA 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 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 of a Metropolitan Statistical Area for Medicare payment regulations and has fewer than 100 beds. We are not preparing an analysis for section 1102(b) of the Act because the Secretary has determined that this proposed rule would 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. In 2011, that threshold is approximately $136 million. This rule would have no consequential effect on State, local, or Tribal governments in the aggregate, or on the private sector.

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 State law, or otherwise has Federalism implications. Since this regulation does not impose any costs on State or local governments, the requirements of Executive Order 13132 are not applicable.

C. Anticipated Effects

1. Effects on State Medicaid Programs

The rule provides States with the option to use certain provisions as well as proposes new requirements or changes to existing interpretations of statutory or regulatory requirements. This rule has multiple purposes, one of which is to provide for a new reconsideration process for administrative determinations to disallow Federal financial participation (FFP). This provision offers States the option of requesting reconsideration of a disallowance to CMS instead of or before requesting reconsideration by the HHS Board, which could reduce legal cost, time, and resources, if a disallowance is reversed by CMS. This provision concerns agency administrative appeals procedures and any direct burden that is imposed on States would not reach the economic threshold. This provision would also not affect substantive rights to administrative determinations consistent with existing statutes and regulations.

Another provision of this rule extends the time period a State has to recover or seek to recover an overpayment made to a Medicaid provider before the State must refund the Federal share of the uncollected overpayment to CMS. This provision updates current regulations to reflect new statutory requirements without substantive changes and we anticipate very slight if any economic impact. The provision also provides that interest will be due from States on Medicaid provider overpayments that are not timely credited. States are already required to credit the Federal share of interest actually earned from overpayments collected from providers, but not refunded to the Federal government within the applicable regulatory timeframe. Although imputing interest on amounts not properly refunded to the Federal Government (whether or not interest was actually earned) may slightly increase the amount owed to the Federal Government, this provision will only affect States that do not refund the Federal share of uncollected provider overpayments to the Federal government within statutory and regulatory timeframes. States may avoid interest liability by returning the Federal share of overpayments within the required timeframe. We believe this change will eliminate an incentive for States to delay timely crediting the Federal government with amounts due.

A third provision of this rule is to revise Medicaid and CHIP regulations related to the disallowance process to allow States the option to retain disputed Federal funds through the administrative review process. We cannot anticipate if States will choose to retain Federal funds through the administrative review process. If States decide to retain Federal funds, they may return the funds before the reconsideration or appeals process is completed without withdrawing the reconsideration or the appeal.

A fourth provision of this rule is to provide that interest charges accrue for any amounts the State opts to retain during these processes. This provision is intended to implement regulations that impose an interest charge on disallowed funds that a State retains pending completion of the administrative reconsideration and/or appeals process. Under section 1903(d)(5) of the Act, a State that wishes to retain the Federal share of a disallowed amount will be liable for interest on the retained funds, based on the average of the bond equivalent of the weekly 90-day treasury bill auction rates, from the date of the disallowance to the date of a final determination. We will assess interest on the funds from the date of the disallowance notice through the date we receive written notice from the State that it no longer wishes to retain the funds or a final determination has been reached through the appeals process.

Although the application of interest through the final determination may slightly increase the amount owed to the Federal Government due to the additional interest charges, this provision does not implement a new requirement or burden to the State. It instead provides States with the opportunity to keep the Federal funds in question during the entire

determination period. However, if the Federal funds are found to be due back to the Federal Government in the final determination, then the State is required to repay the accrued interest in addition to the disallowed amount. States may opt to pay the disallowed amounts at the time of the original disallowance in order to avoid interest charges.

We have also clarified current CMS policy in this rule that a State that has given a timely written notice of its intent to repay by installments to CMS will accrue interest during the repayment schedule on a quarterly basis at the Treasury Current Value Fund Rate (CVFR), from:

(1) The date of the disallowance notice, if the State requests a repayment schedule during the 60-day review period and does not request reconsideration by CMS or appeal to the Board within the 60-day review period.

(2) The date of the final determination of the administrative reconsideration, if the State requests a repayment schedule during the 60-day review period following the CMS final determination and does not appeal to the Board.

(3) The date of the final determination by the Board, if the State requests a repayment schedule during the 60-day review period following the Board's final determination.

A fifth provision of this rule is to revise installment repayment standards and schedules. This provision will provide States with more flexibility in repaying large amounts of Federal funds. We anticipate that the revised repayment schedule will ease the burden for States in periods of economic downturn and allow them to operate their program more effectively. States may choose repayment by installments in lieu of returning a large sum of FFP in a short period of time. States could potentially qualify for an alternate repayment schedule if they meet the regulatory requirements. We will charge interest on the funds from the date of the disallowance notice through the date we receive final payment of the repayment schedule. Although this may marginally increase the amount owed to the Federal Government due to the additional interest charges, the extended repayment schedule is purely an option for States, rather than a new requirement. This provision provides States the ability to analyze what method and timeline of repayment would work best for the State given the circumstances within the State at the time.

The remaining provisions of this rule make technical corrections, revise internal delegations of authority for administrative determinations, and remove obsolete language. These provisions merely update the regulations that are currently in effect without substantive changes.

D. Alternatives Considered

This section provides an overview of regulatory alternatives that we considered for this proposed rule. In determining the appropriate guidance to assist States in their efforts to meet Federal requirements, we conducted analysis and research in both the public and private sector. Based, in part, on this analysis and research we arrived at the provisions proposed in this rule.

1. Administrative Review of Determinations To Disallow Claims for FFP

In this section of the proposed rule, we are setting out procedures for States to request a reconsideration of a disallowance to the CMS Administrator. The proposed process is to be a quick and efficient process for States to point out clear errors or omissions in disallowance determinations, relating either to facts or policy interpretations, that can be corrected before the parties incur further time and expense in an appeal to the Board. Disputes that involve complex fact-finding or issues of legal authority are not appropriate for this expedited review process.

We considered the use of a conference, which would occur once the Administrator had reviewed the reconsideration documents. Either the Administrator or the State would have been able to request to schedule an informal conference. The purpose of the conference would have been to give the State an opportunity to make an oral presentation and give both parties an opportunity to clarify issues and questions about matters which may have been in question. We rejected this process because we do not believe such an option would achieve the objective to have a quick and efficient process relating either to facts or policy interpretations. Such a process could cause delays in resolving the disallowed funds sufficient to create additional burden to State budgets in the form of interest on disallowed amounts, legal fees, and utilization of resources, time and effort. There would also be an additional burden to States on the record retention requirements.

2. Repayment of Federal Funds by Installments

In this section of the proposed rule, we are proposing three schedules including schedules that recognize the unique fiscal pressures of States that are experiencing economic distress. We considered eliminating the threshold, which is based on a percentage of the estimated annual State's share of Medicaid expenditures, to qualify for a repayment schedule and establishing a repayment schedule based on dividing the overpayment amount by a standard 12-quarter schedule. We rejected this option because we wanted to ensure that States that request a repayment schedule would have a substantial amount in overpayments to repay and were not merely making token payments.

We also considered keeping the current percentage of 2.5 percent as the threshold, but due to the current economic downturn and the current strain on States' budgets, we decided to provide some relief and flexibility to States in the form of reducing the required amount of the estimated annual State's share of Medicaid expenditures to qualify for a repayment schedule.

In developing the alternate repayment schedules, we considered several different data sources to develop qualifying criteria for States seeking an alternate repayment schedule due to economic distress. We looked for indicators which were readily available to the States and CMS, transparent to the public, robust in its measurement of economic health, based on the most recent data possible, consistent across States, and predictably available on a regular basis in a timely manner. We also attempted to find a measure that mirrored as closely as possible the criteria used by the National Bureau of Economic Research (NBER) to determine a national recession.

We researched several potential economic distress measures and consulted various entities including the National Association of State Budget Officers, the Rockefeller Institute, the Philadelphia Federal Reserve Bank, and the Government Accountability Office (GAO). The main options we considered were a model used by the GAO, the Philadelphia Federal Reserve Bank State coincident index, and the measure of whether a State qualifies for extended benefits in the Unemployment Insurance program overseen by the U. S. Department of Labor. The GAO index is used to provide information to Congress on State level economic health. It provided much of what we believed would be necessary to accurately measure overall economic health. However, it is not publicly available nor is it replicated on a predictable basis. The Unemployment Insurance program provided data that was timely, accurate, and publicly available. However, it did not appear to be the most robust

measure of total economic health in a State, nor did it closely reflect the type of information used by the NBER.

E. Conclusion

For the reasons discussed above, we are not preparing analysis for either the RFA or section 1102(b) of the Act because we have determined that this regulation will not have a direct significant economic impact on a substantial number of small entities or a direct 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

42 CFR Part 430

Administrative practice and procedure, Grant programs—health, Medicaid, Reporting and recordkeeping requirements.

42 CFR Part 433

Administrative practice and procedure, Child support, Claims, Grant programs—health, Medicaid, Reporting and recordkeeping requirements.

42 CFR Part 447

Accounting, Administrative practice and procedure, Drugs, Grant programs—health, Health facilities, Health professions, Medicaid, Reporting and recordkeeping requirements, Rural areas.

42 CFR Part 457

Administrative practice and procedure, Grant programs—health, Health insurance, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services proposes to amend 42 CFR Chapter IV, as set forth below:

PART 430—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

1. The authority citation for part 430 continues to read as follows:

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

Subpart C—Grants; Reviews and Audits; Withholding for Failure To Comply; Deferral and Disallowance of Claims; Reduction of Federal Medicaid Payments

2. Section 430.30 is amended by revising paragraph (b) to read as follows:

§ 430.30 Grants procedures.

* * * * *

(b) *Quarterly estimates.* The Medicaid agency must submit Form CMS–37 (Medicaid Program Budget Report; Quarterly Distribution of Funding Requirements) to the central office (with a copy to the regional office) 45 days before the beginning of each quarter.

* * * * *

3. Section 430.33 is amended by revising paragraph (c)(2) to read as follows:

§ 430.33 Audits.

* * * * *

(c) * * *

(2) *Appeal.* Any exceptions that are not disposed of under paragraph (c)(1) of this section are included in a disallowance letter that constitutes the Department's final decision unless the State requests reconsideration by the Administrator or the Appeals Board. (Specific rules are set forth in § 430.42.)

* * * * *

4. Section 430.40 is amended by revising paragraphs (a)(1), (b)(1) introductory text, (c)(3), (c)(5), (c)(6), and (e)(1) to read as follows:

§ 430.40 Deferral of claims for FFP.

(a) * * *

(1) The Consortium Administrator for Medicaid or the Administrator questions its allowability and needs additional information in order to resolve the question; and

* * * * *

(b) * * *

(1) Within 15 days of the action described in paragraph (a)(2) of this section, the Consortium Administrator sends the State a written notice of deferral that—

* * * * *

(c) * * *

(3) If the Consortium Administrator finds that the materials are not in readily reviewable form or that additional information is needed, he or she promptly notifies the State that it has 15 days to submit the readily reviewable or additional materials.

* * * * *

(5) The Consortium Administrator has 90 days, after all documentation is available in readily reviewable form, to determine the allowability of the claim.

(6) If the Consortium Administrator cannot complete review of the material within 90 days, CMS pays the claim, subject to a later determination of allowability.

* * * * *

(e) * * *

(1) The Consortium Administrator or the Administrator gives the State written notice of his or her decision to pay or disallow a deferred claim.

* * * * *

5. Section 430.42 is amended by—

A. Revising paragraphs (a) introductory text and paragraph (a)(9).

B. Redesignating paragraphs (b), (c), and (d), as paragraphs (f), (g), and (h) respectively.

C. Adding new paragraphs (b), (c), (d), and (e).

D. Revising the paragraph heading of newly designated paragraph (f).

E. Revising newly designated paragraph (f)(2).

F. Adding new paragraph (f)(3).

G. Revising newly designated paragraphs (g) and (h).

The revisions and additions read as follows:

§ 430.42 Disallowance of claims for FFP.

(a) *Notice of disallowance and of right to reconsideration.* When the Consortium Administrator or the Administrator determines that a claim or portion of claim is not allowable, he or she promptly sends the State a disallowance letter that includes the following, as appropriate:

* * * * *

(9) A statement indicating that the disallowance letter is the Department's final decision unless the State requests reconsideration under paragraph (b)(2) or (f)(2) of this section.

(b) *Reconsideration of disallowances determination.* (1) The Administrator will reconsider Medicaid disallowance determinations.

(2) To request reconsideration of a disallowance, a State must complete the following:

(i) Submit the following within 60 days after receipt of the disallowance letter:

(A) A written request to the Administrator that includes the following:

(*1*) A copy of the disallowance letter.

(*2*) A statement of the amount in dispute.

(*3*) A brief statement of why the disallowance should be reversed or revised, including any information to support the State's position with respect to each issue.

(*4*) Additional information regarding factual matters or policy considerations.

(B) A copy of the written request to the Consortium Administrator.

(C) Send all requests for reconsideration via registered or certified mail to establish the date the reconsideration was received by CMS.

(ii) In all cases, the State has the burden of documenting the allowability of its claims for FFP.

(iii) Additional information regarding the legal authority for the disallowance will not be reviewed in the reconsideration but may be presented in any appeal to the Departmental Appeals Board under paragraph (f)(2) of this section.

(3) A State may request to retain the FFP during the reconsideration of the disallowance under section 1116(e) of the Act, in accordance with § 433.38 of this subchapter.

(4) The State is not required to request reconsideration before seeking review from the Departmental Appeals Board.

(5) The State may also seek reconsideration, and following the reconsideration decision, request a review from the Board.

(6) If the State elects reconsideration, the reconsideration process must be completed or withdrawn before requesting review by the Board.

(c) *Procedures for reconsideration of a disallowance.* (1) Within 60 days after receipt of the disallowance letter, the State shall, in accordance with (b)(2) of this section, submit in writing to the Administrator any relevant evidence, documentation, or explanation and shall simultaneously submit a copy thereof to the appropriate Consortium Administrator.

(2) After consideration of the policies and factual matters pertinent to the issues in question, the Administrator shall, within 60 days from the date of receipt of the request for reconsideration, issue a written decision or a request for additional information as described in the following subparagraph.

(3) At the Administrator's option, CMS may request from the State any additional information or documents necessary to make a decision. The request for additional information must be sent via registered or certified mail to establish the date the request was sent by CMS and received by the State.

(4) Within 30 days after receipt of the request for additional information, the State must submit to the Administrator, with a copy to the Consortium Administrator in readily reviewable form, all requested documents and materials.

(i) If the Administrator finds that the materials are not in readily reviewable form or that additional information is needed, he or she shall notify the State via registered or certified mail that it has 15 business days from the date of receipt of the notice to submit the readily reviewable or additional materials.

(ii) If the State does not provide the necessary materials within 15 business days from the date of receipt of such notice, the Administrator shall affirm the disallowance in a final reconsideration decision issued within 15 days from the due date of additional information from the State.

(5) If additional documentation is provided in readily reviewable form under the paragraph (c)(4) of this section, the Administrator shall issue a written decision, within 60 days from the due date of such information.

(6) The final written decision shall constitute final CMS administrative action on the reconsideration and shall be (within 15 business days of the decision) mailed to the State agency via registered or certified mail to establish the date the reconsideration decision was received by the State.

(7) If the Administrator does not issue a decision within 60 days from the date of receipt of the request for reconsideration or the date of receipt of the requested additional information, the disallowance shall be deemed to be affirmed upon reconsideration.

(8) No section of this regulation shall be interpreted as waiving the Department's right to assert any provision or exemption under the Freedom of Information Act.

(d) *Withdrawal of a request for reconsideration of a disallowance.* (1) A State may withdraw the request for reconsideration at any time before the notice of the reconsideration decision is received by the State without affecting its right to submit a notice of appeal to the Board. The request for withdrawal must be in writing and sent to the Administrator, with a copy to the Consortium Administrator, via registered or certified mail.

(2) Within 60 days after CMS' receipt of a State's withdrawal request, a State may, in accordance with (f)(2) of this section, submit a notice of appeal to the Board.

(e) *Implementation of decisions for reconsideration of a disallowance.* (1) After undertaking a reconsideration, the Administrator may affirm, reverse, or revise the disallowance and shall issue a final written reconsideration decision to the State in accordance with paragraph (c)(4) of this section.

(2) If the reconsideration decision requires an adjustment of FFP, either upward or downward, a subsequent grant award will be issued in the amount of such increase or decrease.

(3) Within 60 days after the receipt of a reconsideration decision from CMS a State may, in accordance with paragraph (f)(2) of this section, submit a notice of appeal to the Board.

(f) *Appeal of Disallowance.* * * * * * * * * *

(2) A State that wishes to request an appeal of a disallowance by the Board must:

(i) Submit a notice of appeal to the Board at the address given on the Departmental Appeals Board's Web site within 60 days after receipt of the disallowance letter.

(A) If a reconsideration of a disallowance was requested, within 60 days after receipt of the reconsideration decision; or

(B) If reconsideration of a disallowance was requested and no written decision was issued, within 60 days from the date the decision on reconsideration of the disallowance was due to be issued by CMS.

(ii) Include all of the following:

(A) A copy of the disallowance letter.

(B) A statement of the amount in dispute.

(C) A brief statement of why the disallowance is wrong.

(3) The Board's decision of an appeal under paragraph (f)(2) of this section shall be the final decision of the Secretary and shall be subject to reconsideration by the Board only upon a motion by either party that alleges a clear error of fact or law and is filed during the 60-day period that begins on the date of the Board's decision or to judicial review in accordance with paragraph (f)(2)(i) of this section.

(g) *Appeals procedures.* The reconsideration procedures are those set forth in 45 CFR part 16 for Medicaid and for many other programs administered by the Department.

(1) In all cases, the State has the burden of documenting the allowability of its claims for FFP.

(2) The Board shall conduct a thorough review of the issues, taking into account all relevant evidence, including such documentation as the State may submit and the Board may require.

(h) *Implementation of decisions.* (1) The Board may affirm the disallowance, reverse the disallowance, modify the disallowance, or remand the disallowance to CMS for further consideration.

(2) The Board will issue a final written decision to the State consistent with 45 CFR Part 16.

(3) If the appeal decision requires an adjustment of FFP, either upward or downward, a subsequent grant award will be issued in the amount of increase or decrease.

6. Section 430.48 is revised to read as follows:

§ 430.48 Repayment of Federal funds by installments.

(a) *Basic conditions.* When Federal payments have been made for claims

that are later found to be unallowable, the State may repay the Federal funds by installments if all of the following conditions are met:

(1) The amount to be repaid exceeds 0.25 percent of the estimated or actual annual State share for the Medicaid program.

(2) The State has given the Consortium Administrator written notice, before total repayment was due, of its intent to repay by installments.

(b) *Annual State share determination.* CMS determines whether the amount to be repaid exceeds 0.25 percent of the annual State share as follows:

(1) If the Medicaid program is ongoing, CMS uses the annual estimated State share of Medicaid expenditures for the current year, as shown on the State's latest Medicaid Program Budget Report (CMS–37). The current year is the year in which the State requests the repayment by installments.

(2) If the Medicaid program has been terminated by Federal law or by the State, CMS uses the actual State share that is shown on the State's CMS–64 Quarterly Expense Report for the last four quarters filed.

(c) *Standard Repayment amounts, schedules, and procedures.* (1) *Repayment amount.* The repayment amount may not include any amount previously approved for installment repayment.

(2) *Repayment schedule.* The maximum number of quarters allowed for the standard repayment schedule is 12 quarters (3 years), except as provided in paragraphs (c)(4) and (e) of this section.

(3) *Quarterly repayment amounts.* (i) The quarterly repayment amounts for each of the quarters in the repayment schedule will be the larger of the repayment amount divided by 12 quarters or the minimum repayment amount;

(ii) The minimum quarterly repayment amounts for each of the quarters in the repayment schedule is 0.25 percent of the estimated State share of the current annual expenditures for Medicaid;

(iii) The repayment period may be less than 12 quarters when the minimum repayment amount is required.

(4) *Extended schedule.* (i) The repayment schedule may be extended beyond 12 quarterly installments if the total repayment amount exceeds 100 percent of the estimated State share of the current annual expenditures;

(ii) The quarterly repayment amount will be 8⅓ percent of the estimated State share of the current annual expenditures until fully repaid.

(5) *Repayment process.* (i) Repayment is accomplished through deposits into the State's Payment Management System (PMS) account;

(ii) A State may choose to make payment by Automated Clearing House (ACH) direct deposit, by check, or by Fedwire transfer.

(6) *Reductions.* If the State chooses to repay amounts representing higher percentages during the early quarters, any corresponding reduction in required minimum percentages is applied first to the last scheduled payment, then to the next to the last payment, and so forth as necessary.

(d) *Alternate repayment amounts, schedules, and procedures for States experiencing economic distress immediately prior to the repayment period.* (1) *Repayment amount.* The repayment amount may not include amounts previously approved for installment repayment if a State initially qualifies for the alternate repayment schedule at the onset of an installment repayment period.

(2) *Qualifying period of economic distress.* (i) A State would qualify to avail itself of the alternate repayment schedule if it demonstrates the State is experiencing a period of economic distress;

(ii) A period of economic distress is one in which the State demonstrates distress for at least each of the previous 6 months, ending the month prior to the date of the State's written request for an alternate repayment schedule, as determined by a negative percent change in the monthly Philadelphia Federal Reserve Bank State coincident index.

(3) *Repayment schedule.* The maximum number of quarters allowed for the alternate repayment schedule is 12 quarters (3 years), except as provided in paragraph (d)(5) of this section.

(4) *Quarterly repayment amounts.* (i) The quarterly repayment amounts for each of the first 8 quarters in the repayment schedule will be the smaller of the repayment amount divided by 12 quarters or the maximum quarterly repayment amount;

(ii) The maximum quarterly repayment amounts for each of the first 8 quarters in the repayment schedule is 0.25 percent of the annual State share determination as defined in paragraph (b) of this section;

(iii) For the remaining 4 quarters, the quarterly repayment amount equals the remaining balance of the overpayment amount divided by the remaining 4 quarters.

(5) *Extended schedule.* (i) For a State that initiated its repayment under an alternate payment schedule for economic distress, the repayment schedule may be extended beyond 12 quarterly installments if the total repayment amount exceeds 100 percent of the estimated State share of current annual expenditures;

(A) In these circumstances, paragraph (d)(3) of this section is followed for repayment of the amount equal to 100 percent of the estimated State share of current annual expenditures.

(B) The remaining amount of the repayment is in quarterly amounts equal to 8⅓ percent of the estimated State share of current annual expenditures until fully repaid.

(ii) Upon request by the State, the repayment schedule may be extended beyond 12 quarterly installments if the State has qualifying periods of economic distress in accordance with paragraph (d)(2) of this section during the first 8 quarters of the alternate repayment schedule.

(A) To qualify for additional quarters, the States must demonstrate a period of economic distress in accordance with paragraph (d)(2) of this section for at least 1 month of a quarter during the first 8 quarters of the alternate repayment schedule.

(B) For each quarter (of the first 8 quarters of the alternate payment schedule) identified as qualified period of economic distress, one quarter will be added to the remaining 4 quarters of the original 12 quarter repayment period.

(C) The total number of quarters in the alternate repayment schedule shall not exceed 20 quarters.

(6) *Repayment process.* (i) Repayment is accomplished through deposits into the State's Payment Management System (PMS) account;

(ii) A State may choose to make payment by Automated Clearing House (ACH) direct deposit, by check, or by Fedwire transfer.

(7) If the State chooses to repay amounts representing higher percentages during the early quarters, any corresponding reduction in required minimum percentages is applied first to the last scheduled payment, then to the next to the last payment, and so forth as necessary.

(e) *Alternate repayment amounts, schedules, and procedures for States entering into distress during a standard repayment schedule.* (1) *Repayment amount.* The repayment amount may include amounts previously approved for installment repayment if a State enters into a qualifying period of economic distress during an installment repayment period.

(2) *Qualifying period of economic distress.* (i) A State would qualify to avail itself of the alternate repayment

schedule if it demonstrates the State is experiencing economic distress;

(ii) A period of economic distress is one in which the State demonstrates distress for each of the previous 6 months, that begins on the date of the State's request for an alternate repayment schedule, as determined by a negative percent change in the monthly Philadelphia Federal Reserve Bank State coincident index.

(3) *Repayment schedule.* The maximum number of quarters allowed for the alternate repayment schedule is 12 quarters (3 years), except as provided in paragraph (e)(5) of this section.

(4) *Quarterly repayment amounts.* (i) The quarterly repayment amounts for each of the first 8 quarters in the repayment schedule will be the smaller of the repayment amount divided by 12 quarters or the maximum repayment amount;

(ii) The maximum quarterly repayment amounts for each of the first 8 quarters in the repayment schedule is 0.25 percent of the annual State share determination as defined in paragraph (b) of this section;

(iii) For the remaining 4 quarters, the quarterly repayment amount equals the remaining balance of the overpayment amount divided by the remaining 4 quarters.

(5) *Extended schedule.* (i) For a State that initiated its repayment under the standard payment schedule and later experienced periods of economic distress and elected an alternate repayment schedule, the repayment schedule may be extended beyond 12 quarterly installments if the total repayment amount of the remaining balance of the standard schedule, exceeds 100 percent of the estimated State share of the current annual expenditures;

(ii) In these circumstances, paragraph (d)(3) of this section is followed for repayment of the amount equal to 100 percent of the estimated State share of current annual expenditures;

(iii) The remaining amount of the repayment is in quarterly amounts equal to 8⅓ percent of the estimated State share of the current annual expenditures until fully repaid.

(6) *Repayment process.* (i) Repayment is accomplished through deposits into the State's Payment Management System (PMS) account;

(ii) A State may choose to make payment by Automated Clearing House (ACH) direct deposit, by check, or by Fedwire transfer.

(7) If the State chooses to repay amounts representing higher percentages during the early quarters, any corresponding reduction in required minimum percentages is applied first to the last scheduled payment, then to the next to the last payment, and so forth as necessary.

PART 433—STATE FISCAL ADMINISTRATION

7. The authority citation for part 433 continues as follows:

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

Subpart A—Federal Matching and General Administration Provisions

8. Section 433.38 is amended by revising paragraphs (a) introductory text, (b)(1), (b)(3), (c), (e)(1)(i),(e)(1)(ii), (e)(1)(iii), (e)(1)(iv), and by adding paragraphs (e)(1)(v), and (e)(1)(vi) to read as follows:

§ 433.38 Interest charge on disallowed claims for FFP.

(a) *Basis and scope.* This section is based on section 1903(d)(5) of the Act, which requires that the Secretary charge a State interest on the Federal share of claims that have been disallowed but have been retained by the State during the administrative appeals process under section 1116(e) of the Act and the Secretary later recovers after the administrative appeals process has been completed. This section does not apply to—

* * * * *

(b) * * *

(1) CMS will charge the State interest on FFP when—

(i) CMS has notified the Medicaid agency under § 430.42 of this subpart that a State's claim for FFP is not allowable;

(ii) The agency has requested a reconsideration of the disallowance to the Administrator under § 430.42 of this chapter and has chosen to retain the FFP during the administrative reconsideration process in accordance with paragraph (c)(2) of this section;

(iii)(A) CMS has made a final determination upholding part or all of the disallowance;

(B) The agency has withdrawn its request for administrative reconsideration on all or part of the disallowance; or

(C) The agency has reversed its decision to retain the funds without withdrawing its request for administrative reconsideration and CMS upholds all or part of the disallowance.

(iv) The agency has appealed the disallowance to the Departmental Appeals Board under 45 CFR Part 16 and has chosen to retain the FFP during the administrative appeals process in accordance with paragraph (c)(2) of this section.

(v)(A)The Board has made a final determination upholding part or all of the disallowance;

(B) The agency has withdrawn its appeal on all or part of the disallowance; or

(C) The agency has reversed its decision to retain the funds without withdrawing its appeal and the Board upholds all or part of the disallowance.

* * * * *

(3) Unless an agency decides to withdraw its request for administrative reconsideration or appeal on part of the disallowance and therefore returns only that part of the funds on which it has withdrawn its request for administrative reconsideration or appeal, any decision to retain or return disallowed funds must apply to the entire amount in dispute.

* * * * *

(c) *State procedures.* (1) If the Medicaid agency has requested administrative reconsideration to CMS or appeal of a disallowance to the Board and wishes to retain the disallowed funds until CMS or the Board issues a final determination, the agency must notify the CMS Consortium Administrator in writing of its decision to do so.

(2) The agency must mail its notice to the CMS Consortium Administrator within 60 days of the date of receipt of the notice of the disallowance, as established by the certified mail receipt accompanying the notice.

(3) If the agency withdraws its decision to retain the FFP or its request for administrative reconsideration or appeal on all or part of the FFP, the agency must notify CMS in writing.

* * * * *

(e) * * *

(1) * * *

(i) On the date of the final determination by CMS of the administrative reconsideration if the State elects not to appeal to the Board, or final determination by the Board;

(ii) On the date CMS receives written notice from the State that it is withdrawing its request for administrative reconsideration and elects not to appeal to the Board, or withdraws its appeal to the Board on all of the disallowed funds; or

(iii) If the agency withdraws its administrative reconsideration on part of the funds on—

(A) The date CMS receives written notice from the agency that it is withdrawing its request for administrative reconsideration on a specified part of the disallowed funds

for the part on which the agency withdraws its request for administrative reconsideration; and

(B) The date of the final determination by CMS on the part for which the agency pursues its administrative reconsideration; or

(iv) If the agency withdraws its appeal on part of the funds, on—

(A) The date CMS receives written notice from the agency that it is withdrawing its appeal on a specified part of the disallowed funds for the part on which the agency withdraws its appeal; and

(B) The date of the final determination by the Board on the part for which the agency pursues its appeal; or

(v) If the agency has given CMS written notice of its intent to repay by installment, in the quarter in which the final installment is paid. Interest during the repayment of Federal funds by installments will be at the Current Value of Funds Rate (CVFR); or

(vi) The date CMS receives written notice from the agency that it no longer chooses to retain the funds.

* * * * *

Subpart F—Refunding of Federal Share of Medicaid Overpayments to Providers

9. Section 433.300 is amended by revising paragraph (b) to read as follows:

§ 433.300 Basis.

* * * * *

(b) Section 1903(d)(2)(C) and (D) of the Act, which provides that a State has 1 year from discovery of an overpayment for Medicaid services to recover or attempt to recover the overpayment from the provider before adjustment in the Federal Medicaid payment to the State is made; and that adjustment will be made at the end of the 1-year period, whether or not recovery is made, unless the State is unable to recover from a provider because the overpayment is a debt that has been discharged in bankruptcy or is otherwise uncollectable.

* * * * *

10. Section 433.302 is revised to read as follows:

§ 433.302 Scope of subpart.

This subpart sets forth the requirements and procedures under which States have 1 year following discovery of overpayments made to providers for Medicaid services to recover or attempt to recover that amount before the States must refund the Federal share of these overpayments to CMS, with certain exceptions.

11. Section 433.304 is amended by removing the definition of ''Abuse'' and adding the definition of ''Final written notice'' to read as follows:

§ 433.304 Definitions.

* * * * *

Final written notice means that written communication, immediately preceding the first level of formal administrative or judicial proceedings, from a Medicaid agency official or other State official that notifies the provider of the State's overpayment determination and allows the provider to contest that determination, or that notifies the State Medicaid agency of the filing of a civil or criminal action.

* * * * *

12. Section 433.312 is amended by revising paragraph (a) to read as follows:

§ 433.312 Basic requirements for refunds.

(a) *Basic rules.* (1) Except as provided in paragraph (b) of this section, the State Medicaid agency has 1 year from the date of discovery of an overpayment to a provider to recover or seek to recover the overpayment before the Federal share must be refunded to CMS.

(2) The State Medicaid agency must refund the Federal share of overpayments at the end of the 1-year period following discovery in accordance with the requirements of this subpart, whether or not the State has recovered the overpayment from the provider.

* * * * *

13. Section 433.316 is amended by revising paragraphs (a), (c) introductory text, (d), (f), and (g) to read as follows:

§ 433.316 When discovery of overpayment occurs and its significance.

(a) *General rule.* The date on which an overpayment is discovered is the beginning date of the 1-year period allowed for a State to recover or seek to recover an overpayment before a refund of the Federal share of an overpayment must be made to CMS.

* * * * *

(c) *Overpayments resulting from situations other than fraud.* An overpayment resulting from a situation other than fraud is discovered on the earliest of—

* * * * *

(d) *Overpayments resulting from fraud.* (1) An overpayment that results from fraud is discovered on the date of the final written notice (as defined in § 433.304 of this subchapter) of the State's overpayment determination.

(2) When the State is unable to recover a debt which represents an overpayment (or any portion thereof) resulting from fraud within 1 year of discovery because no final determination of the amount of the overpayment has been made under an administrative or judicial process (as applicable), including as a result of a judgment being under appeal, no adjustment shall be made in the Federal payment to such State on account of such overpayment (or any portion thereof) until 30 days after the date on which a final judgment (including, if applicable, a final determination on an appeal) is made.

(3) The Medicaid agency may treat an overpayment made to a Medicaid provider as resulting from fraud under subsection (d) of this section only if it has referred a provider's case to the Medicaid fraud control unit, or appropriate law enforcement agency in States with no certified Medicaid fraud control unit, as required by § 455.15, § 455.21, or § 455.23 of this chapter, and the Medicaid fraud control unit or appropriate law enforcement agency has provided the Medicaid agency with written notification of acceptance of the case; or if the Medicaid fraud control unit or appropriate law enforcement agency has filed a civil or criminal action against a provider and has notified the State Medicaid agency.

* * * * *

(f) *Effect of changes in overpayment amount.* Any adjustment in the amount of an overpayment during the 1-year period following discovery (made in accordance with the approved State plan, Federal law and regulations governing Medicaid, and the appeals resolution process specified in State administrative policies and procedures) has the following effect on the 1-year recovery period:

(1) A downward adjustment in the amount of an overpayment subject to recovery that occurs after discovery does not change the original 1-year recovery period for the outstanding balance.

(2) An upward adjustment in the amount of an overpayment subject to recovery that occurs during the 1-year period following discovery does not change the 1-year recovery period for the original overpayment amount. A new 1-year period begins for the incremental amount only, beginning with the date of the State's written notification to the provider regarding the upward adjustment.

(g) *Effect of partial collection by State.* A partial collection of an overpayment amount by the State from a provider during the 1-year period following discovery does not change the 1-year recovery period for the balance of the original overpayment amount due to CMS.

* * * * *

14. Section 433.318 is amended by revising paragraphs (a)(2), (b) introductory text, (c) introductory text, (c)(1), (d)(1), and (e), to read as follows:

§ 433.318 Overpayments involving providers who are bankrupt or out of business.

(a) * * *

(2) The agency must notify the provider that an overpayment exists in any case involving a bankrupt or out-of-business provider and, if the debt has not been determined uncollectable, take reasonable actions to recover the overpayment during the 1-year recovery period in accordance with policies prescribed by applicable State law and administrative procedures.

(b) *Overpayment debts that the State need not refund.* Overpayments are considered debts that the State is unable to recover within the 1-year period following discovery if the following criteria are met:

* * * * *

(c) *Bankruptcy.* The agency is not required to refund to CMS the Federal share of an overpayment at the end of the 1-year period following discovery, if—

(1) The provider has filed for bankruptcy in Federal court at the time of discovery of the overpayment or the provider files a bankruptcy petition in Federal court before the end of the 1-year period following discovery; and

* * * * *

(d) * * *

(1) The agency is not required to refund to CMS the Federal share of an overpayment at the end of the 1-year period following discovery if the provider is out of business on the date of discovery of the overpayment or if the provider goes out of business before the end of the 1-year period following discovery.

* * * * *

(e) *Circumstances requiring refunds.* If the 1-year recovery period has expired before an overpayment is found to be uncollectable under the provisions of this section, if the State recovers an overpayment amount under a court-approved discharge of bankruptcy, or if a bankruptcy petition is denied, the agency must refund the Federal share of the overpayment in accordance with the procedures specified in § 433.320 of this subpart.

15. Section 433.320 is amended by—

A. Revising paragraphs (a)(2), (b)(1), (d), (f)(2), (g)(1), and (h)(1).

B. Adding paragraph (a)(4).

The revisions and addition read as follows:

§ 433.320 Procedures for refunds to CMS.

(a) * * *

(2) The agency must credit CMS with the Federal share of overpayments subject to recovery on the earlier of—

(i) The Form CMS–64 submission due to CMS for the quarter in which the State recovers the overpayment from the provider; or

(ii) The Form CMS–64 due to CMS for the quarter in which the 1-year period following discovery, established in accordance with Sec. 433.316, ends.

* * * * *

(4) If the State does not refund the Federal share of such overpayment as indicated in paragraph (a)(2), the State will be liable for interest on the amount equal to the Federal share of the non-recovered, non-refunded overpayment amount. Interest during this period will be at the Current Value of Funds Rate (CVFR), and will accrue beginning on the day after the end of the 1-year period following discovery until the last day of the quarter for which the State submits a CMS–64 report refunding the Federal share of the overpayment.

(b) * * *

(1) The State is not required to refund the Federal share of an overpayment at the end of the 1-year period if the State has already reported a collection or submitted an expenditure claim reduced by a discrete amount to recover the overpayment prior to the end of the 1-year period following discovery.

* * * * *

(d) *Expiration of 1-year recovery period.* If an overpayment has not been determined uncollectable in accordance with the requirements of § 433.318 of this subpart at the end of the 1-year period following discovery of the overpayment, the agency must refund the Federal share of the overpayment to CMS in accordance with the procedures specified in paragraph (a) of this section.

* * * * *

(f) * * *

(2) The Form CMS–64 submission for the quarter in which the 1-year period following discovery of the overpayment ends.

(g) * * *

(1) If a provider is determined bankrupt or out of business under this section after the 1-year period following discovery of the overpayment ends and the State has not been able to make complete recovery, the agency may reclaim the amount of the Federal share of any unrecovered overpayment amount previously refunded to CMS. CMS allows the reclaim of a refund by the agency if the agency submits to CMS documentation that it has made reasonable efforts to obtain recovery.

* * * * *

(h) * * *

(1) Amounts of overpayments not collected during the quarter but refunded because of the expiration of the 1-year period following discovery;

* * * * *

16. Section 433.322 is revised to read as follows:

§ 433.322 Maintenance of Records.

The Medicaid agency must maintain a separate record of all overpayment activities for each provider in a manner that satisfies the retention and access requirements of 45 CFR 92.42.

PART 447—PAYMENTS FOR SERVICES

17. The authority citation for part 447 continues as follows:

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

Subpart C—Payment for Inpatient Hospital and Long-Term Care Facility Services

§ 447.272 [Amended]

18. Section 447.272 is amended by removing paragraphs (e) and (f).

Subpart E—Payment Adjustments for Hospitals That Serve a Disproportionate Number of Low-Income Patients

19. Section 447.299 is amended by revising paragraph (c)(15) to read as follows:

§ 447.299 Reporting requirements.

* * * * *

(c) * * *

(15) *Total uninsured IP/OP uncompensated care costs.* Total annual amount of uncompensated IP/OP care for furnishing inpatient hospital and outpatient hospital services to individuals with no source of third party coverage for the hospital services they receive.

(i) The amount should be the result of subtracting paragraphs (c)(12) and (c)(13), from paragraph (c)(14) of this section.

(ii) The uncompensated care costs of providing physician services to the uninsured cannot be included in this amount.

(iii) The uninsured uncompensated amount also cannot include amounts associated with unpaid co-pays or deductibles for individuals with third party coverage for the inpatient and/or outpatient hospital services they receive or any other unreimbursed costs

associated with inpatient and/or outpatient hospital services provided to individuals with those services in their third party coverage benefit package.

(iv) The uncompensated care costs do not include bad debt or payer discounts related to services furnished to individuals who have health insurance or other third party payer.

* * * * *

Subpart F—Payment Methods for Other Institutional and Non-Institutional Services

§ 447.321 [Amended]

20. Section 447.321 is amended by removing paragraphs (e) and (f).

PART 457—ALLOTMENTS AND GRANTS TO STATES

21. The authority citation for part 457 continues as follows:

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

Subpart B—General Administration—Reviews and Audits; Withholding for Failure To Comply; Deferral and Disallowance of Claims; Reduction of Federal Medical Payments

§ 457.210 [Removed]

22. Section 457.210 is removed.

§ 457.212 [Removed]

23. Section 457.212 is removed.

§ 457.218 [Removed]

24. Section 457.218 is removed.

Subpart F—Payments to States

25. Section 457.628 is amended by revising paragraph (a) to read as follows:

§ 457.628 Other applicable Federal regulations.

* * * * *

(a) HHS regulations in § 433.312 through § 433.322 of this chapter (related to Overpayments); § 433.38 of this chapter (Interest charge on disallowed claims of FFP); § 430.40 through § 430.42 of this chapter (Deferral of claims for FFP and Disallowance of claims for FFP); § 430.48 of this chapter (Repayment of Federal funds by installments); § 433.50 through § 433.74 of this chapter (sources of non-Federal share and Health Care-Related Taxes and Provider Related Donations); and § 447.207 of this chapter (Retention of Payments) apply to State's CHIP programs in the same manner as they apply to State's Medicaid programs.

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

Dated: February 2, 2011.

Donald M. Berwick,

Administrator, Centers for Medicare & Medicaid Services.

Approved: July 27, 2011.

Kathleen Sebelius,

Secretary, Department of Health and Human Services.

[FR Doc. 2011–19528 Filed 8–2–11; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

44 CFR Part 67

[Docket ID FEMA–2011–0002; Internal Agency Docket No. FEMA–B–1207]

Proposed Flood Elevation Determinations

AGENCY: Federal Emergency Management Agency, DHS.

ACTION: Proposed rule.

SUMMARY: Comments are requested on the proposed Base (1% annual-chance) Flood Elevations (BFEs) and proposed BFE modifications for the communities listed in the table below. The purpose of this proposed rule is to seek general information and comment regarding the proposed regulatory flood elevations for the reach described by the downstream and upstream locations in the table below. The BFEs and modified BFEs are a part of the floodplain management measures that the community is required either to adopt or to show evidence of having in effect in order to qualify or remain qualified for participation in the National Flood Insurance Program (NFIP). In addition, these elevations, once finalized, will be used by insurance agents and others to calculate appropriate flood insurance premium rates for new buildings and the contents in those buildings.

DATES: Comments are to be submitted on or before November 1, 2011.

ADDRESSES: The corresponding preliminary Flood Insurance Rate Map (FIRM) for the proposed BFEs for each community is available for inspection at the community's map repository. The respective addresses are listed in the table below.

You may submit comments, identified by Docket No. FEMA–B–1207, to Luis Rodriguez, Chief, Engineering Management Branch, Federal Insurance and Mitigation Administration, Federal Emergency Management Agency, 500 C Street SW., Washington, DC 20472, (202) 646–4064, or (e-mail) *luis.rodriguez1@dhs.gov.*

FOR FURTHER INFORMATION CONTACT: Luis Rodriguez, Chief, Engineering Management Branch, Federal Insurance and Mitigation Administration, Federal Emergency Management Agency, 500 C Street SW., Washington, DC 20472, (202) 646–4064, or (e-mail) *luis.rodriguez1@dhs.gov.*

SUPPLEMENTARY INFORMATION: The Federal Emergency Management Agency (FEMA) proposes to make determinations of BFEs and modified BFEs for each community listed below, in accordance with section 110 of the Flood Disaster Protection Act of 1973, 42 U.S.C. 4104, and 44 CFR 67.4(a).

These proposed BFEs and modified BFEs, together with the floodplain management criteria required by 44 CFR 60.3, are the minimum that are required. They should not be construed to mean that the community must change any existing ordinances that are more stringent in their floodplain management requirements. The community may at any time enact stricter requirements of its own or pursuant to policies established by other Federal, State, or regional entities. These proposed elevations are used to meet the floodplain management requirements of the NFIP and also are used to calculate the appropriate flood insurance premium rates for new buildings built after these elevations are made final, and for the contents in those buildings.

Comments on any aspect of the Flood Insurance Study and FIRM, other than the proposed BFEs, will be considered. A letter acknowledging receipt of any comments will not be sent.

National Environmental Policy Act. This proposed rule is categorically excluded from the requirements of 44 CFR part 10, Environmental Consideration. An environmental impact assessment has not been prepared.

Regulatory Flexibility Act. As flood elevation determinations are not within the scope of the Regulatory Flexibility Act, 5 U.S.C. 601–612, a regulatory flexibility analysis is not required.

Executive Order 12866, Regulatory Planning and Review. This proposed rule is not a significant regulatory action under the criteria of section 3(f) of Executive Order 12866, as amended.

Executive Order 13132, Federalism. This proposed rule involves no policies that have federalism implications under Executive Order 13132.