

deductibles and daily coinsurance amounts paid.

V. Waiver of Proposed Notice and Comment Period

The Medicare statute, as discussed previously, requires publication of the Medicare Part A inpatient hospital deductible and the hospital and extended care services coinsurance amounts for services for each calendar year. The amounts are determined according to the statute. As has been our custom, we use general notices, rather than notice and comment rulemaking procedures, to make the announcements. In doing so, we acknowledge that, under the Administrative Procedure Act (APA), interpretive rules, general statements of policy, and rules of agency organization, procedure, or practice are excepted from the requirements of notice and comment rulemaking.

We considered publishing a proposed notice to provide a period for public comment. However, we may waive that procedure if we find good cause that prior notice and comment are impracticable, unnecessary, or contrary to the public interest. We find that the procedure for notice and comment is unnecessary because the formulae used to calculate the inpatient hospital deductible and hospital and extended care services coinsurance amounts are statutorily directed, and we can exercise no discretion in following those formulae. Moreover, the statute establishes the time period for which the deductible and coinsurance amounts will apply and delaying publication would be contrary to the public interest. Therefore, we find good cause to waive publication of a proposed notice and solicitation of public comments.

VI. Regulatory Impact Statement

We have examined the impacts of this notice as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96-354), section 1102(b) of the Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104-4), and Executive Order 13132.

Executive Order 12866, which merely reassigns responsibility of duties) directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). As stated in Section IV of this notice, we estimate that the total

increase in costs to beneficiaries associated with this notice is about \$230 million due to: (1) The increase in the deductible and coinsurance amounts and (2) the change in the number of deductibles and daily coinsurance amounts paid. Therefore, this notice is a major rule as defined in Title 5, United States Code, section 804(2), and is an economically significant rule under Executive Order 12866.

The RFA requires agencies to analyze options for regulatory relief of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and government agencies. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of \$6 million to \$29 million in any 1 year. Individuals and States are not included in the definition of a small entity. We have determined that this notice will not have a significant economic impact on a substantial number of small entities. Therefore we are not preparing an analysis for the RFA.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 100 beds. We have determined that this notice will not have a significant effect on the operations of a substantial number of small rural hospitals. Therefore, we are not preparing an analysis for section 1102(b) of the Act.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule that may result in expenditure in any 1 year by State, local, or tribal governments, in the aggregate, or by the private sector, of \$110 million. This notice has no consequential effect on State, local, or tribal governments or on the private sector.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a 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. This notice has no consequential effect on State or local governments.

In accordance with the provisions of Executive Order 12866, this regulation

was reviewed by the Office of Management and Budget.

Authority: Sections 1813(b)(2) of the Social Security Act (42 U.S.C. 1395e-2(b)(2)).

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance)

Dated: September 12, 2005.

Mark B. McClellan,

Administrator, Centers for Medicare & Medicaid Services.

Dated: September 15, 2005.

Michael O. Leavitt,

Secretary.

[FR Doc. 05-18838 Filed 9-16-05; 4:00 pm]

BILLING CODE 4120-01-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS-1307-GNC]

RIN 0938-ZA74

Medicare Program; Criteria and Standards for Evaluating Intermediary, Carrier, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Regional Carrier Performance During Fiscal Year 2006

AGENCY: Centers for Medicare and Medicaid Services (CMS), Health and Human Services (HHS).

ACTION: General notice with comment period.

SUMMARY: This notice describes the criteria and standards to be used for evaluating the performance of fiscal intermediaries (FIs), carriers, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) regional carriers in the administration of the Medicare program beginning on the first day of the first month following publication of this notice in the **Federal Register**. The results of these evaluations are considered whenever we enter into, renew, or terminate an intermediary agreement, carrier contract, or DMEPOS regional carrier contract or take other contract actions, for example, assigning or reassigning providers or services to an intermediary or designating regional or national intermediaries. We are requesting public comment on these criteria and standards.

DATES: *Effective Date:* The criteria and standards are effective on October 24, 2005.

Comment Date: To be assured consideration, comments must be received at one of the addresses

provided below, no later than 5 p.m. beginning on the first day of the first month following publication of this notice in the **Federal Register**.

ADDRESSES: In commenting, please refer to file code CMS-1307-GNC. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of three ways (no duplicates, please):

1. *Electronically.* You may submit electronic comments on specific issues in this regulation to <http://www.cms.hhs.gov/regulations/ecomments> or to <http://www.regulations.gov>, (attachments must be in Microsoft Word, WordPerfect, or Excel; however, we prefer Microsoft Word.)

2. *By mail.* You may mail written comments (one original and two copies) to the following address only: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-1307-GNC, P.O. Box 8013, Baltimore, MD 21244-8013.

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

3. *By hand or courier.* If you prefer, you may deliver (by hand or courier) your written comments (one original and two copies) before the close of the comment period to one of the following addresses. If you intend to deliver your comments to the Baltimore address, please call telephone number (410) 786-7197 in advance to schedule your arrival with one of our staff members. Room 445-G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201; or 7500 Security Boulevard, Baltimore, MD 21244-1850.

(Because access to the interior of the HHH Building is not readily available to persons without Federal Government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and could be considered late. 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. After the close of the comment period, CMS posts all

electronic comments received before the close of the comment period on its public website.

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

FOR FURTHER INFORMATION CONTACT: Richard Johnson, (410) 786-5633.

SUPPLEMENTARY INFORMATION:

Submitting Comments: We welcome comments from the public on all issues set forth in this notice to assist us in fully considering issues and developing policies. You can assist us by referencing the file code CMS-1307-GNC and the specific "issue identifier" that precedes the section on which you choose to comment.

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 electronic comments received before the close of the comment period on its public website as soon as possible after they are received. Hard copy comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1-800-743-3951.

I. Background

[If you choose to comment on issues in this section, please include the caption "BACKGROUND" at the beginning of your comments.]

A. Part A—Hospital Insurance

Under section 1816 of the Social Security Act (the Act), public or private organizations and agencies participate in the administration of Part A (Hospital Insurance) of the Medicare program under agreements with us. These agencies or organizations, known as FIs, determine whether medical services are covered under Medicare, determine correct payment amounts and then make payments to the health care providers (for example, hospitals, skilled nursing facilities (SNFs), and community mental health centers) on behalf of the beneficiaries. Section 1816(f) of the Act requires us to develop criteria, standards, and procedures to evaluate an intermediary's performance of its functions under its agreement.

Section 1816(e)(4) of the Act requires us to designate regional agencies or organizations, which are already Medicare intermediaries under section 1816 of the Act, to perform claim processing functions for freestanding Home Health Agency (HHA) claims. We refer to these organizations as Regional Home Health Intermediaries (RHHIs). See § 421.117 and the final rule published on May 19, 1988 in the **Federal Register** (53 FR 17936) for more details about the RHHIs.

The evaluation of intermediary performance is part of our contract management process. These evaluations need not be limited to the current fiscal year (FY), other fixed term basis, or agreement term.

B. Part B—Supplementary Medical Insurance

Under section 1842 of the Act, we are authorized to enter into contracts with carriers to fulfill various functions in the administration of Part B, Supplementary Medical Insurance of the Medicare program. Beneficiaries, physicians, and suppliers of services submit claims to these carriers. The carriers determine whether the services are covered under Medicare and the amount payable for the services or supplies, and then make payment to the appropriate party.

Under section 1842(b)(2) of the Act, we are required to develop criteria, standards, and procedures to evaluate a carrier's performance of its functions under its contract. Evaluations of Medicare fee-for-service (FFS) contractor performance need not be limited to the current FY, other fixed term basis, or contract term. The evaluation of carrier performance is part of our contract management process.

C. Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Regional Carriers

In accordance with section 1834(a)(12) of the Act, we have entered into contracts with four DMEPOS regional carriers to perform all of the duties associated with the processing of claims for DMEPOS, under Part B of the Medicare program. These DMEPOS regional carriers process claims based on a Medicare beneficiary's principal residence by State. Section 1842(a) of the Act authorizes contracts with carriers for the payment of Part B claims for Medicare covered services and items. Section 1842(b)(2) of the Act requires us to publish in the **Federal Register** criteria and standards for the efficient and effective performance of carrier contract obligations. Evaluation of Medicare FFS contractor performance

need not be limited to the current FY, other fixed term basis, or contract term. The evaluation of DMEPOS regional carrier performance is part of our contract management process.

D. Development and Publication of Criteria and Standards

In addition to the statutory requirements, § 421.120, § 421.122 and § 421.201 provide for publication of a **Federal Register** notice to announce criteria and standards for intermediaries and carriers before the beginning of each evaluation period. The current criteria and standards for intermediaries, carriers, and DMEPOS regional carriers were published in the **Federal Register** (68 FR 74613) on November 26, 2004.

To the extent possible, we make every effort to publish the criteria and standards before the beginning of the Federal FY, which is October 1. If we do not publish a **Federal Register** notice before the new FY begins, readers may presume that until and unless notified otherwise, the criteria and standards that were in effect for the previous FY remain in effect.

In those instances in which we are unable to meet our goal of publishing the subject **Federal Register** notice before the beginning of the FY, we may publish the criteria and standards notice at any subsequent time during the year. If we publish a notice in this manner, the evaluation period for the criteria and standards that are the subject of the notice will be effective beginning on the first day of the first month following publication of this notice in the **Federal Register**. Any revised criteria and standards will measure performance prospectively; that is, any new criteria and standards in the notice will be applied only to performance after the effective date listed on the notice.

It is not our intention to revise the criteria and standards that will be used during the evaluation period once this information is published in a **Federal Register** notice. However, on occasion, either because of administrative action or statutory mandate, there may be a need for changes that have a direct impact on the criteria and standards previously published, or that require the addition of new criteria or standards, or that cause the deletion of previously published criteria and standards. If we must make these changes, we will publish an amended **Federal Register** notice before implementation of the changes. In all instances, necessary manual issuances will be published to ensure that the criteria and standards are applied uniformly and accurately. Also, as in previous years, this **Federal Register** notice will be republished and

the effective date revised if changes are warranted as a result of the public comments received on the criteria and standards.

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) (Pub. L. 108-173) was enacted on December 8, 2003. Section 911 of the MMA establishes the Medicare FFS Contracting Reform (MCR) initiative that will be implemented over the next several years. This provision requires that we use competitive procedures to replace our current FIs and carriers with Medicare Administrative Contractors (MACs). The MMA requires that we compete and transition all work to MACs by October 1, 2011.

FIs and or carriers will continue administering Medicare FFS work until the final competitively selected MAC is up and operating. We will continue to develop and publish standards and criteria for use in evaluating the performance of FIs, carriers, and DMERCs as long as these types of contractors exist.

II. Analysis of and Response to Public Comments Received on FY 2005 Criteria and Standards

We received three comments in response to the November 26, 2004 **Federal Register** general notice with comments. All comments were reviewed, but none necessitated our reissuance of the FY 2005 Criteria and Standards. Comments submitted did not pertain specifically to the FY 2005 criteria and standards.

III. Criteria and Standards—General

[If you choose to comment on issues in this section, please include the caption “CRITERIA AND STANDARDS—GENERAL” at the beginning of your comments.]

Basic principles of the Medicare program are to pay claims promptly and accurately and to foster good beneficiary and provider relations. Contractors must administer the Medicare program efficiently and economically. The goal of performance evaluation is to ensure that contractors meet their contractual obligations. We measure contractor performance to ensure that contractors do what is required of them by statute, regulation, contract, and our directives.

We have developed a contractor oversight program for FY 2006 that outlines expectations of the contractor, measures the performance of the contractor; evaluates the performance against the expectations; and provides for appropriate contract action based upon the evaluation of the contractor's performance.

As a means to monitor the accuracy of Medicare FFS payments, we have established the Comprehensive Error Rate Testing (CERT) program that measures and reports error rates for claims payment decisions made by carriers, DMERCs, and FIs. Beginning in November 2003, the CERT program measures and reports claims payment error rates for each individual carrier and DMERC. FI-specific rates became available November 2004. These rates measure not only how well contractors are doing at implementing automated review edits and identifying which claims to subject to manual medical review but they also measure the impact of the contractor's provider outreach/education, as well as the effectiveness of the contractor's provider call center(s). We will use these contractor-specific error rates as a means to evaluate a contractor's performance.

Several times throughout this notice, we refer to the appropriate reading level of letters, decisions, or correspondence that are going to Medicare beneficiaries from intermediaries or carriers. In those instances, appropriate reading level is defined as whether the communication is below the 8th grade reading level unless it is obvious that an incoming request from the beneficiary contains language written at a higher level. In these cases, the appropriate reading level is tailored to the capacities and circumstances of the intended recipient.

In addition to evaluating performance based upon expectations for FY 2006, we may also conduct follow-up evaluations throughout FY 2006 of areas in which contractor performance was out of compliance with statute, regulations, and our performance expectations during prior review years where contractors were required to submit a Performance Improvement Plan (PIP).

We may also utilize Statement of Auditing Standards-70 (SAS-70) reviews as a means to evaluate contractors in some or all business functions.

In FY 2001, we established the Contractor Rebuttal Process as a commitment to continual improvement of contractor performance evaluation (CPE). We will continue the use of this process in FY 2006. The Contractor Rebuttal Process provides the contractors an opportunity to submit a written rebuttal of CPE findings of fact. Whenever we conduct an evaluation of contractor operations, contractors have 7 calendar days from the date of the CPE review exit conference to submit a written rebuttal. The CPE review team or, if appropriate, the individual reviewer will consider the contents of

the rebuttal before the issuance of the final CPE report to the contractor.

The FY 2006 CPE for intermediaries and carriers is structured into five criteria designed to meet the stated objectives. The first criterion, claims processing, measures contractual performance against claims processing accuracy and timeliness requirements, as well as activities in handling appeals. Within the claims processing criterion, we have identified those performance standards that are mandated by legislation, regulation, or judicial decision. These standards include claims processing timeliness, the accuracy of Medicare Summary Notices (MSNs), the timeliness of intermediary redeterminations, the timeliness of carrier redeterminations and hearings, and the appropriateness of the reading level and content of intermediary and carrier redetermination letters. Further evaluation in the Claims Processing Criterion may include, but is not limited to, the accuracy of claims processing, the percent of claims paid with interest, and the accuracy of redeterminations and carrier hearings.

The second criterion, customer service, assesses the adequacy of the service provided to customers by the contractor in its administration of the Medicare program. The mandated standard in the customer service criterion is the need to provide beneficiaries with written replies that are responsive, that is, they provide in detail the reasons for a determination when a beneficiary requests this information, they have a customer-friendly tone and clarity, and they are at the appropriate reading level. Further evaluation of services under this criterion may include, but will not be limited to, the following: Timeliness and accuracy of all correspondence both to beneficiaries and providers; monitoring of the quality of replies provided by the contractor's telephone customer service representatives (quality call monitoring); beneficiary and provider education, training, and outreach activities; and service provided by the contractor's customer service representatives to beneficiaries and providers who come to the contractor's facility (walk-in inquiry service).

The third criterion, payment safeguards, evaluates whether the Medicare Trust Fund is safeguarded against inappropriate program expenditures. Intermediary and carrier performance may be evaluated in the areas of Medical Review (MR), Medicare Secondary Payer (MSP), Overpayments (OP), and Provider Enrollment (PE). In addition, intermediary performance may

be evaluated in the area of Audit and Reimbursement (A&R).

In FY 1996 the Congress enacted the Health Insurance Portability and Accountability Act (HIPAA), Medicare Integrity Program, giving us the authority to contract with entities other than, but not excluding, Medicare carriers and intermediaries to perform certain program safeguard functions. In situations where one or more program safeguard functions are contracted to another entity, we may evaluate the flow of communication and information between a Medicare FFS contractor and the payment safeguard contractor. All benefit integrity functions have been transitioned from intermediaries, carriers, and one DMERC to the program safeguard contractors. Since, the other three DMERC contractors will continue to conduct benefit integrity activities in FY 2006, we may evaluate their performance of that function.

Mandated performance standards for intermediaries in the payment safeguards criterion include the accuracy of decisions on SNF demand bills and the timeliness of processing Tax Equity and Fiscal Responsibility Act (TEFRA) target rate adjustments, exceptions, and exemptions. There are no mandated performance standards for carriers in the payment safeguards criterion. Intermediaries and carriers may also be evaluated on any Medicare Integrity Program (MIP) activities if performed under their agreement or contract.

The fourth criterion, fiscal responsibility, evaluates the contractor's efforts to protect the Medicare program and the public interest. Contractors must effectively manage Federal funds for both the payment of benefits and the costs of administration under the Medicare program. Proper financial and budgetary controls, including internal controls, must be in place to ensure contractor compliance with its agreement with HHS and CMS.

Additional functions reviewed under this criterion may include, but are not limited to, adherence to approved budget, compliance with the Budget and Performance Requirements (BPRs), and compliance with financial reporting requirements.

The fifth and final criterion, administrative activities, measures a contractor's administrative management of the Medicare program. A contractor must efficiently and effectively manage its operations. Proper systems security (general and application controls), Automated Data Processing (ADP) maintenance, and disaster recovery plans must be in place. A contractor's evaluation under the administrative

activities criterion may include, but is not limited to, establishment, application, documentation, and effectiveness of internal controls that are essential in all aspects of a contractor's operation, as well as the degree to which the contractor cooperates with us in complying with the Federal Managers' Financial Integrity Act of 1982 (FMFIA). Administrative activities evaluations may also include reviews related to contractor implementation of our general instructions and data and reporting requirements.

We have developed separate measures for RHHIs in order to evaluate the distinct RHHI functions. These functions include the processing of claims from freestanding HHAs, hospital-affiliated HHAs, and hospices. Through an evaluation using these criteria and standards, we may determine whether the RHHI is effectively and efficiently administering the program benefit or whether the functions should be moved from one intermediary to another in order to gain that assurance.

In sections IV through VII of this notice, we list the criteria and standards to be used for evaluating the performance of intermediaries, RHHIs, carriers, and DMEPOS regional carriers.

IV. Criteria and Standards for Intermediaries

[If you choose to comment on issues in this section, please include the caption "CRITERIA AND STANDARDS FOR INTERMEDIARIES" at the beginning of your comments.]

A. Claims Processing Criterion

The claims processing criterion contains the following four mandated standards:

Standard 1. Not less than 95.0 percent of clean electronically submitted non-Periodic Interim Payment claims are paid within statutorily specified time frames. Clean claims are defined as claims that do not require Medicare intermediaries to investigate or develop them outside of their Medicare operations on a prepayment basis. Specifically, the statute specifies that clean non-Periodic Interim Payment electronic claims be paid no earlier than the 14th day after the date of receipt, and that interest is payable for any clean claims if payment is not issued by the 31st day after the date of receipt. The HIPAA Administrative Simplification provisions and the implementing regulations established standards for electronic transmission of claims. We issued instructions that effective July 1, 2004, electronic claims that do not comply with the appropriate HIPAA

claim standard will no longer qualify for payment as early as the 14th day after the date of receipt. These "non-HIPAA" claims will not be paid earlier than the 27th day after the date of receipt. These "non-HIPAA" claims will continue to have interest payable if payment is not issued by the 31st day after the date of receipt. Our expectation is that contractors will pay 95 percent of these clean claims by the 31st day (30 days after date of receipt) on a monthly basis.

Standard 2. Not less than 95.0 percent of clean paper non-Periodic Interim Payment claims are paid within specified time frames. Specifically, clean non-Periodic Interim Payment paper claims can be paid as early as the 27th day (26 days after the date of receipt) and must be paid by the 31st day (30 days after the date of receipt). Our expectation is that contractors will meet this percentage on a monthly basis.

Standard 3. Redetermination letters prepared in response to beneficiary-initiated appeal requests are written in a manner calculated to be understood by the beneficiary. Letters must contain the required elements as specified in § 405.956.

Standard 4. All redeterminations must be concluded and mailed within 60 days of receipt of the request, unless the appellant submits documentation after the request, in which case the decision making timeframe is extended for 14 calendar days for each submission.

Because intermediaries process many claims for benefits under the Part B portion of the Medicare Program, we also may evaluate how well an intermediary follows the procedures for processing appeals of any claims for Part B benefits.

Additional functions that may be evaluated under this criterion include, but are not limited to, the following:

- Accuracy of claims processing.
- Remittance advice transactions.
- Establishment and maintenance of a relationship with Common Working File (CWF) Host.

- Accuracy of redeterminations as well as the appropriateness of the reading level of any redetermination decision letters.

- Accuracy and timeliness of processing appeals under section 521 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) and sections 933 and 940 of the MMA.

Note: Section 521 of BIPA and sections 933 and 940 of MMA amend section 1869 of the Act by requiring major revisions to the Medicare appeals process. Section 937 of MMA also requires the creation of a process outside the appeals process, whereby Medicare contractors can correct minor errors

and omissions. We may evaluate compliance with our instructions concerning other provisions of section 521 of BIPA and sections 933, 937 and 940 of MMA as they are implemented.

B. Customer Service Criterion

Functions that may be evaluated under this criterion include, but are not limited to, the following:

- Maintaining a properly programmed interactive voice response system to assist with provider inquiries.
- Performing quality call monitoring.
- Training customer service representatives.

- Entering valid call center performance data in the customer service assessment and management system.

- Providing timely and accurate written replies to beneficiaries and/or providers that address the concerns raised and are written with an appropriate customer-friendly tone and clarity and those written to beneficiaries are at the appropriate reading level.

- Maintaining walk-in inquiry service for beneficiaries and providers.

- Conducting beneficiary and provider education, training, and outreach activities.

- Effectively maintaining an Internet website dedicated to furnishing providers and physicians timely, accurate, and useful Medicare program information.

- Ensuring written correspondence is evaluated for quality.

C. Payment Safeguards Criterion

The Payment Safeguard criterion contains the following two mandated standards:

Standard 1. Decisions on SNF demand bills are accurate.

Standard 2. TEFRA target rate adjustments, exceptions, and exemptions are processed within mandated time frames. Specifically, applications must be processed to completion within 75 days after receipt by the contractor or returned to the hospitals as incomplete within 60 days of receipt.

Intermediaries may also be evaluated on any MIP activities if performed under their Part A contractual agreement. These functions and activities include, but are not limited to, the following:

- Audit and Reimbursement
 - + Performing the activities specified in our general instructions for conducting audit and settlement of Medicare cost reports.
 - + Establishing accurate interim payments.
- Benefit Integrity

- + Referring allegations of potential fraud that are made by beneficiaries, providers, CMS, Office of Inspector General (OIG), and other sources to the Payment Safeguard Contractor.

- + Putting in place effective detection and deterrence programs for potential fraud.

- Medical Review

- + Increasing the effectiveness of medical review activities.

- + Exercising accurate and defensible decision making on medical reviews.

- + Effectively educating and communicating with the provider community.

- + Collaborating with other internal components and external entities to ensure the effectiveness of medical review activities.

- Medicare Secondary Payer

- + Accurately reporting MSP savings.

- + Accurately following MSP claim development and edit procedures.

- + Auditing hospital files and claims to determine that claims are being filed to Medicare appropriately.

- + Supporting the Coordination of Benefits Contractors' efforts to identify responsible payers primary to Medicare.

- + Identifying, recovering, and referring mistaken/conditional Medicare payments in accordance with appropriate Medicare Manual instructions and any other pertinent general instructions, in the specified order of priority.

- Overpayments

- + Collecting and referring Medicare debts timely.

- + Accurately reporting and collecting overpayments.

- + Adhering to our instructions for management of Medicare Trust Fund debts.

- Provider Enrollment

- + Complying with assignment of staff to the provider enrollment function and training the staff in procedures and verification techniques.

- + Complying with the operational standards relevant to the process for enrolling providers.

D. Fiscal Responsibility Criterion

We may review the intermediary's efforts to establish and maintain appropriate financial and budgetary internal controls over benefit payments and administrative costs. Proper internal controls must be in place to ensure that contractors comply with their agreements with us.

Additional functions that may be reviewed under the fiscal responsibility criterion include, but are not limited to, the following:

- Adherence to approved program management and MIP budgets.

- Compliance with the BPRs.
- Compliance with financial reporting requirements.
- Control of administrative cost and benefit payments.

E. Administrative Activities Criterion

We may measure an intermediary's administrative ability to manage the Medicare program. We may evaluate the efficiency and effectiveness of its operations, its system of internal controls, and its compliance with our directives and initiatives.

We may measure an intermediary's efficiency and effectiveness in managing its operations. Proper systems security (general and application controls), ADP maintenance, and disaster recovery plans must be in place. An intermediary must also test system changes to ensure the accurate implementation of our instructions.

Our evaluation of an intermediary under the administrative activities criterion may include, but is not limited to, reviews of the following:

- Systems security.
- ADP maintenance (configuration management, testing, change management, and security).
- Implementation of the Electronic Data Interchange (EDI) standards adopted for use under HIPAA.
- Disaster recovery plan and systems contingency plan.
- Data and reporting requirements implementation.
- Internal controls establishment and use, including the degree to which the contractor cooperates with the Secretary in complying with the FMFIA.
- Implementation of our general instructions.

V. Criteria and Standards for Regional Home Health Intermediaries (RHHIs)

[If you choose to comment on issues in this section, please include the caption "CRITERIA AND STANDARDS FOR RHHIs" at the beginning of your comments.]

The following four standards are mandated for the RHHI criterion:

Standard 1. Not less than 95.0 percent of clean electronically submitted non-Periodic Interim Payment home health and hospice claims are paid within statutorily specified time frames. Clean claims are defined as claims that do not require Medicare intermediaries to investigate or develop them outside of their Medicare operations on a prepayment basis. Specifically, the statute specifies that clean non-Periodic Interim Payment electronic claims be paid no earlier than the 14th day after the date of receipt, and that interest is payable for any clean claims if payment

is not issued by the 31st day after the date of receipt. The HIPAA Administrative Simplification provisions and the implementing regulations established standards for electronic transmission of claims. We issued instructions that effective July 1, 2004, electronic claims that do not comply with the appropriate HIPAA claim standard will no longer qualify for payment as early as the 14th day after the date of receipt. These "non-HIPAA" claims will not be paid earlier than the 27th day after the date of receipt. These "non-HIPAA" claims will continue to have interest payable if payment is not issued by the 31st day after the date of receipt. Our expectation is that contractors will pay 95 percent of these clean claims by the 31st day (30 days after date of receipt) on a monthly basis.

Standard 2. Not less than 95.0 percent of clean paper non-periodic interim payment home health and hospice claims are paid within specified time frames. Specifically, clean, non-periodic interim payment paper claims can be paid as early as the 27th day (26 days after the date of receipt) and must be paid by the 31st day (30 days after the date of receipt). Our expectation is that contractors will meet this percentage on a monthly basis.

Standard 3. Redetermination letters prepared in response to beneficiary initiated appeal requests are written in a manner calculated to be understood by the beneficiary. Letters must contain the required elements as specified in § 405.956.

Standard 4: All redeterminations must be concluded and mailed within 60 days of receipt of the request, unless the appellant submits documentation after the request, in which case the decision making timeframe is extended for 14 calendar days for each submission.

We may use this criterion to review an RHHI's performance for handling the HHA and hospice workload. This includes processing HHA and hospice claims timely and accurately, properly paying and settling HHA cost reports, and timely and accurately processing BIPA section 521 redeterminations from beneficiaries, HHAs, and hospices.

Note: Section 521 of BIPA and sections 933 and 940 of MMA amend section 1869 of the Act by requiring major revisions to the Medicare appeals process. Section 937 of MMA requires the creation of a process outside the appeals process, whereby Medicare contractors can correct minor errors and omissions. We may evaluate compliance with our instructions concerning other provisions of section 521 of BIPA and sections 933, 937 and 940 of MMA as they are implemented.

VI. Criteria and Standards for Carriers

[If you choose to comment on issues in this section, please include the caption "CRITERIA AND STANDARDS FOR CARRIERS" at the beginning of your comments.]

A. Claims Processing Criterion

The Claims Processing criterion contains the following six mandated standards:

Standard 1. Not less than 95.0 percent of clean electronically submitted claims are processed within statutorily specified time frames. Clean claims are defined as claims that do not require Medicare carriers to investigate or develop them outside of their Medicare operations on a prepayment basis. Specifically, the statute specifies that clean non-Periodic Interim payment electronic claims be paid no earlier than the 14th day after the date of receipt, and that interest is payable for any clean claims if payment is not issued by the 31st day after the date of receipt. The HIPAA Administrative Simplification provisions and the implementing regulations established standards for electronic transmission of claims. We issued instructions that effective July 1, 2004, electronic claims that do not comply with the appropriate HIPAA claim standard will no longer qualify for payment as early as the 14th day after the date of receipt. These "non-HIPAA" claims will not be paid earlier than the 27th day after the date of receipt. These "non-HIPAA" claims will continue to have interest payable if payment is not issued by the 31st day after the date of receipt. Our expectation is that contractors will pay 95 percent of these clean claims by the 31st day (30 days after date of receipt) on a monthly basis.

Standard 2. Not less than 95.0 percent of clean paper claims are processed within specified time frames. Specifically, clean paper claims can be paid as early as the 27th day (26 days after the date of receipt) and must be paid by the 31st day (30 days after the date of receipt). Our expectation is that contractors will meet this percentage on a monthly basis.

Standard 3. 98.0 percent of MSNs are properly generated. Our expectation is that MSN messages are accurately reflecting the services provided.

Standard 4. 90.0 percent of carrier hearing decisions are completed within 120 days. Our expectation is that contractors will meet this percentage on a monthly basis. This standard will remain in effect until the Part B hearing officer work is transitioned to the QICs sometime in FY 2006.

Standard 5. Redetermination letters prepared in response to beneficiary

initiated appeal requests are written in a manner calculated to be understood by the beneficiary. Letters must contain the required elements as specified in § 405.956.

Standard 6. All redeterminations must be concluded and mailed within 60 days of receipt of the request, unless the appellant submits documentation after the request, in which case the decision making time frame is extended for 14 calendar days for each submission.

Additional functions that may be evaluated under this criterion include, but are not limited to, the following:

- Accuracy of claims processing.
- Remittance advice transactions.
- Establishment and maintenance of relationship with Common Working File (CWF) Host.
- Accuracy of redetermination decisions.
- Accuracy of processing hearing cases with decision letters that are clear and have an appropriate customer-friendly tone. This standard will remain in effect until the Part B hearing officer work is transitioned to the QICs sometime in FY 2006.
- Accuracy and timeliness of appeals decisions issued pursuant to the requirements of BIPA section 521 and sections 933 and 940 of MMA.

Note: Section 521 of BIPA and sections 933 and 940 of MMA amend section 1869 of the Act by requiring major revisions to the Medicare appeals process. Section 937 of MMA also requires the creation of a process outside the appeals process, whereby Medicare contractors can correct minor errors and omissions. We may evaluate compliance with our instructions concerning other provisions of section 521 of BIPA and sections 933, 937 and 940 of MMA as they are implemented.

B. Customer Service Criterion

The customer service criterion contains the following mandated standard: Replies to beneficiary written correspondence are responsive to the beneficiary's concerns, are written with an appropriate customer-friendly tone and clarity, and are written at the appropriate reading level.

Contractors must meet our performance expectations that beneficiaries and providers are served by prompt and accurate administration of the program in accordance with all applicable laws, regulations, and our general instructions.

Additional functions that may be evaluated under this criterion include, but are not limited to, the following:

- Maintaining a properly programmed interactive voice response system to assist with provider inquiries.
- Performing quality call monitoring.

- Training customer service representatives.
- Entering valid call center performance data in the customer service assessment and management system.
- Providing timely and accurate written replies to beneficiary and/or providers.

- Maintaining walk-in inquiry service for beneficiaries and providers.
- Conducting beneficiary and provider education, training, and outreach activities.
- Effectively maintaining an internet website dedicated to furnishing providers timely, accurate, and useful Medicare program information.
- Ensuring written correspondence is evaluated for quality.

- Effectively maintaining an internet website dedicated to furnishing providers timely, accurate, and useful Medicare program information.
- Ensuring written correspondence is evaluated for quality.

C. Payment Safeguards Criterion

Carriers may be evaluated on any MIP activities if performed under their contracts. In addition, other carrier functions and activities that may be reviewed under this criterion include, but are not limited to the following:

- Benefit Integrity
 - + Referring allegations of potential fraud that are made by beneficiaries, providers, CMS, OIG, and other sources to the payment safeguard contractor.
 - + Putting in place effective detection and deterrence programs for potential fraud.
- Medical Review
 - + Increasing the effectiveness of medical review activities.
 - + Exercising accurate and defensible decision making on medical reviews.
 - + Effectively educating and communicating with the provider community.
 - + Collaborating with other internal components and external entities to ensure the effectiveness of medical review activities.

- Medicare Secondary Payer
 - + Accurately reporting MSP savings.
 - + Accurately following MSP claim development/edit procedures.
 - + Supporting the Coordination of Benefits Contractor's efforts to identify responsible payers primary to Medicare.
 - + Identifying, recovering, and referring mistaken/conditional Medicare payments in accordance with the appropriate *Medicare Manual* instructions, and our other pertinent general instructions.

- Overpayments
 - + Collecting and referring Medicare debts timely.
 - + Accurately reporting and collecting overpayments.
 - + Compliance with our instructions for management of Medicare Trust Fund debts.

- Provider Enrollment
 - + Complying with assignment of staff to the provider enrollment function and training staff in procedures and verification techniques.
 - + Complying with the operational standards relevant to the process for enrolling suppliers.

D. Fiscal Responsibility Criterion

We may review the carrier's efforts to establish and maintain appropriate financial and budgetary internal controls over benefit payments and administrative costs. Proper internal controls must be in place to ensure that contractors comply with their contracts.

Additional functions that may be reviewed under the Fiscal Responsibility criterion include, but are not limited to, the following:

- Adherence to approved program management and MIP budgets.
- Compliance with the BPRs.
- Compliance with financial reporting requirements.
- Control of administrative cost and benefit payments.

E. Administrative Activities Criterion

We may measure a carrier's administrative ability to manage the Medicare program. We may evaluate the efficiency and effectiveness of its operations, its system of internal controls, and its compliance with our directives and initiatives.

We may measure a carrier's efficiency and effectiveness in managing its operations. Proper systems security (general and application controls), ADP maintenance, and disaster recovery plans must be in place. Also, a carrier must test system changes to ensure accurate implementation of our instructions.

Our evaluation of a carrier under this criterion may include, but is not limited to, reviews of the following:

- Systems security.
- ADP maintenance (configuration management, testing, change management, and security).
- Disaster recovery plan/systems contingency plan.
- Data and reporting requirements implementation.
- Internal controls establishment and use, including the degree to which the contractor cooperates with the Secretary in complying with the FMFIA.
- Implementation of the Electronic Data Interchange (EDI) standards adopted for use under the Health Insurance Portability and Accountability Act (HIPAA).
- Implementation of our general instructions.

VII. Criteria and Standards for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Regional Carriers

[If you choose to comment on issues in this section, please include the caption "CRITERIA AND STANDARDS FOR DMEPOS" at the beginning of your comments.]

The five criteria for DMEPOS regional carriers contain a total of six mandated standards against which all DMEPOS regional carriers must be evaluated.

There also are examples of other activities for which the DMEPOS regional carriers may be evaluated. The mandated standards are in the claims processing and customer service criteria. In addition to being described in these criteria, the mandated standards are also described in the DMEPOS regional carrier statement of work (SOW).

A. Claims Processing Criterion

The claims processing criterion contains the following six mandated standards:

Standard 1. Not less than 95.0 percent of clean electronically submitted claims are processed within statutorily specified time frames. Clean claims are defined as claims that do not require Medicare DMEPOS regional carriers to investigate or develop them outside of their Medicare operations on a prepayment basis. Specifically, the statute specifies that clean non-Periodic Interim Payment electronic claims be paid no earlier than the 14th day after the date of receipt, and that interest is payable for any clean claims if payment is not issued by the 31st day after the date of receipt. The HIPAA Administrative Simplification provisions and the implementing regulations established standards for electronic transmission of claims. We issued instructions that effective July 1, 2004, electronic claims that do not comply with the appropriate HIPAA claim standard will no longer qualify for payment as early as the 14th day after the date of receipt. These "non-HIPAA" claims will not be paid earlier than the 27th day after the date of receipt. These "non-HIPAA" claims will continue to have interest payable if payment is not issued by the 31st day after the date of receipt. Our expectation is that contractors will pay 95 percent of these clean claims by the 31st day (30 days after date of receipt) on a monthly basis.

Standard 2. Not less than 95.0 percent of clean paper claims are processed within specified timeframes. Specifically, clean paper claims can be paid as early as day 27 (26 days after the

date of receipt) and must be paid by day 31 (30 days after the date of receipt). Our expectation is that contractors will meet this percentage on a monthly basis.

Standard 3. 98.0 percent of MSNs are properly generated. Our expectation is that MSN messages are accurately reflecting the services provided.

Standard 4. 90.0 percent of DMEPOS regional carrier hearing decisions are completed within 120 days. Our expectation is that contractors will meet this percentage on a monthly basis. This standard will remain in effect until the Part B hearing officer work is transitioned to the QICs sometime in FY 2006.

Standard 5. Redetermination letters prepared in response to beneficiary initiated appeal requests are written in a manner calculated to be understood by the beneficiary. Letters must contain the required elements as specified in § 405.956.

Standard 6. All redeterminations must be concluded and mailed within 60 days of receipt of the request, unless the appellant submits documentation after the request, in which case the decision making timeframe is extended for 14 calendar days for each submission.

Additional functions that may be evaluated under this criterion include, but are not limited to, the following:

- Claims processing accuracy.
- Accuracy and timeliness of appeals decisions prior to the implementation of BIPA sections 521 and 933 and section 940 of MMA requirements.
- Requests for ALJ hearings are forwarded timely.
- Accuracy and timeliness of appeals decisions issued pursuant to the requirements of BIPA sections 521 and 933 and section 940 of MMA.

Note: Section 521 of BIPA and sections 933 and 940 of MMA amend section 1869 of the Act by requiring major revisions to the Medicare appeals process. Section 937 of MMA also requires the creation of a process outside the appeals process, whereby Medicare contractors can correct minor errors and omissions. We may evaluate compliance with our instructions concerning other provisions of section 521 of BIPA and sections 933, 937 and 940 of MMA as they are implemented.

B. Customer Service Criterion

The customer service criterion contains the following mandated standard: Replies to beneficiary written correspondence are responsive to the beneficiary's concerns, are written with an appropriate customer-friendly tone and clarity, and are written at the appropriate reading level.

Contractors must meet our performance expectations that

beneficiaries and suppliers are served by prompt and accurate administration of the program in accordance with all applicable laws, regulations, the DMEPOS regional carrier SOW, and our general instructions.

Additional functions that may be evaluated under this criterion include, but are not limited to, the following:

- Maintaining a properly programmed interactive voice response system to assist with provider inquiries.
- Performing quality call monitoring.
- Training customer service representatives.
- Entering valid call center performance data in the customer service assessment and management system.
- Providing timely and accurate written replies to beneficiaries and/or providers.
- Maintaining walk-in inquiry service for beneficiaries and suppliers.
- Conducting beneficiary and provider education, training, and outreach activities.
- Effectively maintaining an internet website dedicated to furnishing providers timely, accurate, and useful Medicare program information.
- Ensuring that communications are made to interested supplier organizations for the purpose of developing and maintaining collaborative supplier education and training activities and programs.
- Ensuring written correspondence is evaluated for quality.

C. Payment Safeguards Criterion

DMEPOS regional carriers may be evaluated on any MIP activities if performed under their contracts. The DMEPOS regional carriers must undertake actions to promote an effective program administration for DMEPOS regional carrier claims. These functions and activities include, but are not limited to the following:

- Benefit Integrity
 - + Identifying potential fraud cases that exist within the DMEPOS regional carrier's service area and taking appropriate actions to resolve these cases.
 - + Investigating allegations of potential fraud made by beneficiaries, suppliers, CMS, OIG, and other sources.
- + Putting in place effective detection and deterrence programs for potential fraud.
- Medical Review
 - + Increasing the effectiveness of medical review activities.
 - + Exercising accurate and defensible decision making on medical reviews.
 - + Effectively educating and communicating with the supplier community.

+ Collaborating with other internal components and external entities to ensure the effectiveness of medical review activities.

- Medicare Secondary Payer
- + Accurately reporting MSP savings.
- + Accurately following MSP claim development/edit procedures.
- + Supporting the coordination of benefits contractors' efforts to identify responsible payers primary to Medicare.
 - Identifying, recovering, and referring mistaken/conditional Medicare payments in accordance with the appropriate program instructions in the specified order of priority.
 - Overpayments
 - + Collecting and referring Medicare debts timely.
 - + Accurately reporting and collecting overpayments.
 - + Compliance with our instructions for management of Medicare Trust Fund debts.

D. Fiscal Responsibility Criterion

We may review the DMEPOS regional carrier's efforts to establish and maintain appropriate financial and budgetary internal controls over benefit payments and administrative costs. Proper internal controls must be in place to ensure that contractors comply with their contracts. Additional matters that may be reviewed under this criterion include, but are not limited to, the following:

- Compliance with financial reporting requirements.
- Adherence to approved program management and MIP budgets.
- Control of administrative cost and benefit payments.

E. Administrative Activities

We may measure a DMEPOS regional carrier's administrative ability to manage the Medicare program. We may evaluate the efficiency and effectiveness of its operations, its system of internal controls, and its compliance with our directives and initiatives. Our evaluation of a DMEPOS regional carrier under this criterion may include, but is not limited to, review of the following:

- Systems security.
- Disaster recovery plan/systems contingency plan.
- Internal controls establishment and use, including the degree to which the contractor cooperates with the Secretary in complying with the FMFIA.
- Implementation of the EDI standards adopted for use under HIPAA.

VIII. Action Based on Performance Evaluations

[If you choose to comment on this section, please include the caption

“ACTION BASED ON PERFORMANCE EVALUATIONS” at the beginning of your comments.]

We evaluate a contractor's performance against applicable program requirements for each criterion. Each contractor must certify that all information submitted to us relating to the contract management process, including, without limitation, all files, records, documents and data, whether in written, electronic, or other form, is accurate and complete to the best of the contractor's knowledge and belief. A contractor is required to certify that its files, records, documents, and data are not manipulated or falsified in an effort to receive a more favorable performance evaluation. A contractor must further certify that, to the best of its knowledge and belief, the contractor has submitted, without withholding any relevant information, all information required to be submitted for the contract management process under the authority of applicable law(s), regulation(s), contract(s), or our manual provision(s). Any contractor that makes a false, fictitious, or fraudulent certification may be subject to criminal or civil prosecution, as well as appropriate administrative action. This administrative action may include debarment or suspension of the contractor, as well as the termination or nonrenewal of a contract.

If a contractor meets the level of performance required by operational instructions, it meets the requirements of that criterion. When we determine a contractor is not meeting performance requirements, we will use the terms “major nonconformance” or “minor nonconformance” to classify our findings. A major nonconformance is a nonconformance that is likely to result in failure of the supplies or services, or to materially reduce the usability of the supplies or services for their intended purpose. A minor nonconformance is a nonconformance that is not likely to materially reduce the usability of the supplies or services for their intended purpose, or is a departure from established standards having little bearing on the effective use or operation of the supplies or services. The contractor will be required to develop and implement PIPs for findings determined to be either a major or minor nonconformance. The contractor will be monitored to ensure effective and efficient compliance with the PIP, and to ensure improved performance when requirements are not met.

The results of performance evaluations and assessments under all criteria applying to intermediaries,

carriers, RHHIs, and DMEPOS regional carriers will be used for contract management activities and will be published in the contractor's annual Report of Contractor Performance (RCP). We may initiate administrative actions as a result of the evaluation of contractor performance based on these performance criteria. Under sections 1816 and 1842 of the Act, we consider the results of the evaluation in our determinations when—

- Entering into, renewing, or terminating agreements or contracts with contractors, and
- Deciding other contract actions for intermediaries and carriers (such as deletion of an automatic renewal clause). These decisions are made on a case-by-case basis and depend primarily on the nature and degree of performance. More specifically, these decisions depend on the following:
 - + Relative overall performance compared to other contractors.
 - + Number of criteria in which nonconformance occurs.
 - + Extent of each nonconformance.
 - + Relative significance of the requirement for which nonconformance occurs within the overall evaluation program.
 - + Efforts to improve program quality, service, and efficiency.
 - + Deciding the assignment or reassignment of providers and designation of regional or national intermediaries for classes of providers.

We make individual contract action decisions after considering these factors in terms of their relative significance and impact on the effective and efficient administration of the Medicare program.

In addition, if the cost incurred by the intermediary, RHHI, carrier, or DMEPOS regional carrier to meet its contractual requirements exceeds the amount that we find to be reasonable and adequate to meet the cost that must be incurred by an efficiently and economically operated intermediary or carrier, these high costs may also be grounds for adverse action.

IX. Collection of Information Requirements

This document does not impose information collection and record keeping requirements. Consequently the Office of Management and Budget need not review it under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*).

X. Response to Comments

Because of the large number of items of correspondence we normally receive on **Federal Register** documents published for comment, we are unable

to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the Comment Period section of this preamble, and, if we proceed with a subsequent document, we will respond to the comments in the preamble of that document.

Authority: Sections 1816(f), 1834(a)(12), and 1842(b) of the Social Security Act (42 U.S.C. 1395h(f), 1395m(a)(12), and 1395u(b)) (Catalog of Federal Domestic Assistance Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: May 19, 2005.

Mark B. McClellan,

Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 05-18923 Filed 9-22-05; 8:45 am]

BILLING CODE 4120-01-U

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS-8025-N]

RIN 0938-AO01

Medicare Program; Part A Premium for Calendar Year 2006 for the Uninsured Aged and for Certain Disabled Individuals Who Have Exhausted Other Entitlement

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

ACTION: Notice.

SUMMARY: This annual notice announces Medicare's Hospital Insurance (Part A) premium for uninsured enrollees in calendar year (CY) 2006. This premium is to be paid by enrollees age 65 and over who are not otherwise eligible (hereafter known as the "uninsured aged") and for certain disabled individuals who have exhausted other entitlement. The monthly Part A premium for the 12 months beginning January 1, 2006 for these individuals will be \$393. The reduced premium for certain other individuals as described in this notice will be \$216. Section 1818(d) of the Social Security Act specifies the method to be used to determine these amounts.

EFFECTIVE DATE: This notice is effective on January 1, 2006.

FOR FURTHER INFORMATION CONTACT: Clare McFarland, (410) 786-6390.

SUPPLEMENTARY INFORMATION:

I. Background

Section 1818 of the Social Security Act (the Act) provides for voluntary

enrollment in the Medicare Hospital Insurance program (Medicare Part A), subject to payment of a monthly premium, of certain persons aged 65 and older who are uninsured under the Old-Age, Survivors and Disability Insurance (OASDI) program or the Railroad Retirement Act and do not otherwise meet the requirements for entitlement to Medicare Part A. (Persons insured under the OASDI program or the Railroad Retirement Act and certain others do not have to pay premiums for hospital insurance.)

Section 1818A of the Act provides for voluntary enrollment in Medicare Part A, subject to payment of a monthly premium, of certain disabled individuals who have exhausted other entitlement. These are individuals who are not currently entitled to Part A coverage, but who were entitled to coverage due to a disabling impairment under section 226(b) of the Act, and who would still be entitled to Part A coverage if their earnings had not exceeded the statutorily defined substantial gainful activity amount (section 223(d)(4) of the Act).

Section 1818A(d)(2) of the Act specifies that the provisions relating to premiums under section 1818(d) through section 1818(f) of the Act for the aged will also apply to certain disabled individuals as described above.

Section 1818(d) of the Act requires us to estimate, on an average per capita basis, the amount to be paid from the Federal Hospital Insurance Trust Fund for services incurred in the following calendar year (including the associated administrative costs) on behalf of individuals aged 65 and over who will be entitled to benefits under Medicare Part A. We must then determine, during September of each year, the monthly actuarial rate for the following year (the per capita amount estimated above divided by 12) and publish the dollar amount for the monthly premium in the succeeding CY. If the premium is not a multiple of \$1, the premium is rounded to the nearest multiple of \$1 (or, if it is a multiple of 50 cents but not of \$1, it is rounded to the next highest \$1).

Section 13508 of the Omnibus Budget Reconciliation Act of 1993 (Pub. L. 103-66) amended section 1818(d) of the Act to provide for a reduction in the premium amount for certain voluntary enrollees (section 1818 and section 1818A). The reduction applies to an individual who is eligible to buy into the Medicare Part A program and who, as of the last day of the previous month—

- Had at least 30 quarters of coverage under title II of the Act;

- Was married, and had been married for the previous 1-year period, to a person who had at least 30 quarters of coverage;

- Had been married to a person for at least 1 year at the time of the person's death if, at the time of death, the person had at least 30 quarters of coverage; or
- Is divorced from a person and had been married to the person for at least 10 years at the time of the divorce if, at the time of the divorce, the person had at least 30 quarters of coverage.

Section 1818(d)(4)(A) of the Act specifies that the premium that these individuals will pay for CY 2006 will be equal to the premium for uninsured aged enrollees reduced by 45 percent.

II. Monthly Premium Amount for CY 2006

The monthly premium for the uninsured aged and certain disabled individuals who have exhausted other entitlement for the 12 months beginning January 1, 2006, is \$393.

The monthly premium for those individuals subject to the 45 percent reduction in the monthly premium is \$216.

III. Monthly Premium Rate Calculation

As discussed in section I of this notice, the monthly Medicare Part A premium is equal to the estimated monthly actuarial rate for CY 2006 rounded to the nearest multiple of \$1 and equals one-twelfth of the average per capita amount, which is determined by projecting the number of Part A enrollees aged 65 years and over as well as the benefits and administrative costs that will be incurred on their behalf.

The steps involved in projecting these future costs to the Federal Hospital Insurance Trust Fund are:

- Establishing the present cost of services furnished to beneficiaries, by type of service, to serve as a projection base;
- Projecting increases in payment amounts for each of the service types; and
- Projecting increases in administrative costs.

We base our projections for CY 2006 on: (a) current historical data, and (b) projection assumptions derived from current law and the Mid-Session Review of the President's Fiscal Year 2006 Budget.

We estimate that in CY 2006, 35.205 million people aged 65 years and over will be entitled to benefits (without premium payment) and that they will incur \$166.121 billion of benefits and related administrative costs. Thus, the estimated monthly average per capita amount is \$393.23 and the monthly