ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 52 and Part 70

[EPA–R02–OAR–2012–0032, FRL–9675–1]

Approval and Promulgation of Implementation Plans and Operating Permits Program; Commonwealth of Puerto Rico; Administrative Changes

AGENCY: Environmental Protection Agency (EPA).

ACTION: Withdrawal of direct final rule.

SUMMARY: Due to an adverse comment, EPA is withdrawing the direct final rule, published on March 22, 2012, that approved revisions to the Puerto Rico Regulations for the Control of Atmospheric Pollution. Those revisions were submitted to EPA by the Puerto Rico Environmental Quality Board on July 13, 2011, and consist of amendments to Rules 102, 111, 115, 116 and Appendix A. Generally the revisions to the regulations involve administrative changes which improve the clarity of the rules contained in the Commonwealth's Implementation Plan and Operating Permits Program.

DATES: The direct final rule is withdrawn as of May 29, 2012.

ADDRESSES: EPA has established docket number EPA–R02–OAR–2012–0032 for this action. Copies of the state submittal(s) are available at the following address for inspection during normal business hours: Environmental Protection Agency, Region 2 Office, Air Programs Branch, 290 Broadway, 25th Floor, New York, New York 10007–1866.

FOR FURTHER INFORMATION CONTACT: Kirk J. Wieber, Air Programs Branch, Environmental Protection Agency, 290 Broadway, 25th Floor, New York, New York 10007–1866, (212) 637–3381.

SUPPLEMENTARY INFORMATION: In the direct final rule published at 77 FR 16676, EPA stated that if we received adverse comments by April 23, 2012, the rule would be withdrawn and not take effect. EPA subsequently received an adverse comment. EPA will address the comment received in a subsequent final action based upon the proposed action also published on March 22, 2012 (77 FR 16795). EPA will not institute a second comment period on this action.

List of Subjects

40 CFR Part 52

Environmental protection, Air pollution control, Incorporation by reference, Intergovernmental relations, Reporting and recordkeeping requirements, Volatile organic compounds.

40 CFR Part 70

Administrative practice and procedure, Air pollution control, Intergovernmental relations, Reporting and recordkeeping requirements.

Dated: May 9, 2012.

Judith A. Enck,

Regional Administrator, Region 2.

[FR Doc. 2012–12783 Filed 5–25–12; 8:45 am]

BILLING CODE 6560–50–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 430, 433, 447, and 457

[CMS–2292–F]

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: Final rule.

SUMMARY: This final rule reflects the Centers for Medicare & Medicaid Services' commitment to the general principles of the President's Executive Order 13563 released January 18, 2011, entitled ''Improving Regulation and Regulatory Review.'' This rule will: 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; and provide that interest charges may accrue during the new administrative reconsideration process if a State chooses to retain the funds during that period. This final rule will also make a technical correction to reporting requirements for disproportionate share hospital payments, revise internal delegations of authority to reflect the term ''Administrator or current Designee,'' remove obsolete language, and correct other technical errors.

DATES: *Effective Date:* These regulations are effective on June 28, 2012.

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:

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 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.

For a detailed description of the background of this final rule, please refer to the proposed rule published on August 3, 2011 (76 FR 46685) in the **Federal Register**.

In addition to the background described in the proposed rule, it is significant that 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 share of the funds. This section of the Affordable Care Act 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. Summary of the Provisions of the Proposed Rule and Response to Comments

This final rule finalizes provisions set forth in the proposed rule (76 FR 46684). The following is a summary of the provisions and the response to the comments received.

A. Administrative Review of Determinations to Disallow Claims for FFP

Section 204 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), Public Law 110–275, entitled Review of Administrative Claim Determinations, amended section 1116 of the Act by striking ''title XIX'' from section 1116(d) of the Act, which describes a reconsideration process for disallowances of claimed Federal financial participation (FFP), and added a new section 1116(e) of the Act which provides for a new process for administrative review of Medicaid disallowances. Under the new process, a State may request a reconsideration of a Medicaid disallowance from the Secretary of the Department of Health and Human Services (Secretary) during the 60-day period following receipt of notice of the disallowance. Alternatively, or in addition, States may obtain review by the Department of Health and Human Services' (HHS) Departmental Appeals Board (Board) of either the initial agency decision or the reconsidered decision. Therefore, we proposed to revise § 430.42 to set forth new procedures to review administrative determinations to disallow claims for FFP. These new procedures will provide for the availability of an informal agency reconsideration and a formal adjudication by the HHS Board.

Specifically, we proposed to amend § 430.42(b) to provide States the option to request administrative reconsideration of an initial determination of a Medicaid disallowance.

In § 430.42(c), we proposed the procedures for such a reconsideration, in § 430.42(d) we described the option for a State to withdraw a reconsideration request, and in § 430.42(e) we described the procedures for issuing reconsideration decisions and implementing such decisions.

In § 430.42(f), we proposed that States would have 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).

In § 430.42(h), we proposed the procedure for issuance and implementation of the final decision. For a detailed description of these options, please refer to the proposed rule (76 FR 46685).

The following is a summary of the comments we received regarding the administrative review of determinations to disallow claims for FFP proposal, and our responses to those comments.

Comment: One commenter disagreed with our proposal to create a regulatory framework where lack of timely action by the Administrator to issue a decision on a request for reconsideration affirms the disallowance. The commenter believes that this provision will undermine any advantage derived from creating an administrative reconsideration process and recommends that the provision be revised so that a lack of timely action by CMS results in a decision in the State's favor.

Response: We do not believe that the implementation of this provision will undermine the advantage that may be provided to a State requesting an administrative reconsideration. Section 1116(e) of the Act provides that a State may appeal an unfavorable reconsideration of a disallowance. We believe that the advantage of creating an administrative reconsideration process is to help reduce legal costs, time, and resources for States and the Federal agency. We believe that the most prudent course is preserving the State's ability to proceed in the reconsideration process to the Board without impediment. This rule affords States the option to proceed to the appeals process without delay even in the event the Administrator does not provide a timely response to the reconsideration.

Comment: One commenter requested that CMS revise the rule so that the agency will automatically suspend its disallowance determination during the internal reconsideration period so that a State will not be liable for interest if it elects to retain disallowed FFP. The commenter also stated that CMS proposed to charge interest during the administrative review period at the Current Value of Funds Rate (CVFR).

Response: We work diligently to ensure that we have reviewed every option to resolve a financial issue before proceeding to the disallowance process and believe that to undo the process would be counterintuitive. The law provides for a request for reconsideration as an additional option for States in the disallowance process before proceeding to an appeal by the Board. Additionally, we believe that the language in section 1903 of the Act is clear and that we have no authority to revise current regulations to suspend a disallowance during the administrative reconsideration process.

Regarding the liability of interest during the reconsideration process, we note that States are not required to request reconsideration and have the option to return the funds to us during the disallowance process. If a State is afforded the option to, and elects to, retain disallowed FFP during the administrative review period, the State 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, in accordance with section 1903(d)(5) of the Act.

Therefore, we are finalizing without change our proposed revisions to § 430.42 as stated in the proposed rule.

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

We proposed to revise § 433.38 to clarify the application of interest when the State opts to retain Federal funds. In § 433.38, we proposed to add language clarifying that interest will accrue on disallowed claims of FFP during both the reconsideration process and the Board appeal process. We also proposed to clarify that, 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, we proposed that the interest would continue to accrue on outstanding balances during any installment repayment period, until the total amount is repaid.

We indicated in the preamble to the proposed rule that we were considering 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 proposed to provide States with an additional option for repaying that interest during a repayment schedule. We believe that allowing greater flexibility in the repayment of interest during the

repayment schedule will assist States as they formulate their budgets.

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 need to pay interest per quarter on the remaining balance of the overpayment until the final payment. To clarify how this option would work, we provided an example in Table 3 of the proposed rule (76 FR 46689); 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.*

For a detailed description of these proposed options, please refer to the proposed rule (76 FR 46686).

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

The following describes the one timely comment we received regarding the State option to retain Federal funds pending administrative review and interest charges on properly disallowed funds retained by the State.

Comment: One commenter strongly recommended that CMS address what they believe to be an inherent inequity in charging interest on disputed funds when a State retains the FFP and loses on reconsideration/appeal. They stated that CMS should pay interest to a State if a State prevails on reconsideration or appeal.

Response: Section 1903(d)(5) of the Act gives the State the option to retain the amount of Federal payment in controversy subject to an interest charge. Section 1903(d)(5) of the Act does not provide authority for CMS to pay a State interest on disputed funds when a State prevails in reconsideration or appeal. Nor do we see any significant equity issue, since interest is only due if a State exercises the option to retain the funds pending resolution of the dispute and it is determined that the State had no entitlement to the use of those funds. Additionally, as the State controls the funds during the reconsideration of appeal, CMS is in no way inhibiting the use of those funds pending resolution of the dispute. States have substantial control over both the quality and documentation of their claims.

Therefore, we are finalizing without change our proposal to revise § 433.38 to clarify the application of interest when the State opts to retain Federal funds as stated in the proposed rule.

C. Repayment of Federal Funds by Installments

We proposed to 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 proposed 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.

For a detailed description of the proposed options and repayment schedules, please refer to the proposed rule (76 FR 46686).

The following is a summary of the comments we received regarding repayment of Federal funds by installments.

Comment: One commenter recommended that CMS clarify the use of the term ''deposits,'' and asked if a State may continue to accomplish repayment through adjustments in the State's Payment Management System (PMS) account. The commenter suggests that CMS' intent may be better reflected by adding ''or adjustments'' to the provision.

Response: The term ''deposit'' as used in § 430.48(c)(5)(i) refers to the State making payment by Automated Clearing House (ACH) direct deposit, by check, or by Fedwire transfer in the State's PMS account. We recognize that the current process for repayment allows for an adjustment in the quarterly grants. Under this rule, a State will no longer be allowed to make repayment (of Federal funds by installments) through adjustments in the quarterly grants (reducing State authority to draw Federal funds) over the period covered by the repayment schedule. Due to the extended repayment periods, we believe that there is a need for accountability in the repayment made to PMS that cannot be attained through adjustments other than actual repayment. Adjustment of the grant award would only ensure actual repayment of the funds at the time of the adjustment if the State were simultaneously reducing its drawdown of federal funds in the same amount as the adjustment. If the State were doing so, the net effect should be the same as actual repayment. Because it would be almost impossible to determine what a State drawdown would have been, there is no way to determine if an actual payment was made until a State has to reconcile at the end of the year. The ability to track and record transactions will be enhanced by requiring actual repayment through Automated Clearing House (ACH) direct deposit, by check, or by Fedwire transfer in the State's PMS account.

We have proposed three new repayment schedules that will allow States additional time (12 quarters) to make repayments, as well as extend the quarters for making repayment during periods of economic distress. The revisions to the repayment process in § 430.48(c)(5) are needed to ensure that we can verify when repayments are made. We believe that the revised language of the section as stated in the proposed rule will permit this verification.

Comment: One commenter expressed belief that it is a reasonable approach to use the Federal Reserve Bank of Philadelphia State coincident index because it is publicly available and routinely updated. The commenter, however, contended that setting the threshold at a negative percent change on each of 6 previous months sets a standard that is too stringent and does not correlate well with State budget experience. The commenter noted that because States use annual and biennial budget processes, the amount of funding a State can free up in the short term for a disallowance may not be related to the most recent 6 months of economic activity; rather, it is likely to be a function of longer term State economic conditions. The commenter also believes that the 6-month standard is unfair and may penalize States that experience a single month of growth during a period of overall economic decline. The commenter suggested that using a comparison of average annual totals based upon the monthly Federal Reserve Bank of Philadelphia State coincident index will better reflect a State's economic distress condition.

Response: The proposed repayment by installments in this rule was developed to provide all States more flexibility and to recognize the unique fiscal pressures of States that are required to repay large amounts to the Federal government. This rule offers three repayment schedules. The establishment of the standard repayment schedule, which will provide all States that qualify a standard 12 quarter repayment, takes into account the fact that most State legislatures will need time to enact appropriations to repay significant amounts. This schedule is intended to assist States with budget concerns that may experience difficulty in freeing up funds in the short term.

We also recognized the need for offering additional relief for States that continued to experience significant economic distress when either initiating a repayment schedule or while currently in the standard repayment process. The alternate repayment schedules were developed to assist only States that are experiencing continuous significant periods of economic distress. The National Bureau of Economic Research (NBER) recognizes that many professionals and experts around the world define a recession as two or more consecutive quarters of declining real Gross Domestic Product (GDP). Our development of a threshold set at a negative percent change on each of 6 previous months is consistent with this widely accepted definition of a recession. The use of a comparison of average annual total seems to be a good measure; however, our research did not identify a widely accepted basis for its use in determining a State's fiscal health.

In consideration of the commenter's suggestion to use a comparison of average annual totals based upon the monthly Federal Reserve Bank of Philadelphia State coincident index, we conducted an analysis to see if the methodology suggested by the commenter will produce significantly different results. The commenter did not define ''average annual totals'' so we defined it for our analysis as the average of the 12 consecutive months prior to the month in which the repayment was requested, resulting in a decline. We performed our analysis using 6 States identified by the commenter as being penalized by the use of the 6-month standard. Our analysis showed that the use of a comparison of average annual total in the States identified did not produce significantly different results. We also note that depending on the percent change identified by the index of a particular 12-month period, in some cases, the use of the average annual totals could have an adverse effect in certain circumstances. For example, if a State has 6 consecutive months of minimal decline preceded by 6 months of growth exceeding the decline, the average annual total for that State will be positive growth. Under the methodology in this rule, that State will qualify for the alternate repayment schedule available upon request, but under the average annual total methodology that State will not qualify. Therefore, for the reasons noted above, we do not believe it will be beneficial to modify our methodology as identified in the proposed rule.

Comment: One commenter stated that the use of the Federal Reserve Bank of Philadelphia to identify periods of economic distress in a State could be a good proxy for future State revenues for States that rely heavily on income taxes, but may be limited in its appropriateness for States that depend heavily on sales taxes. The commenter suggested that this indicator does not measure distress that comes from State spending obligations, including natural disasters, retiree pension and health care, State Medicaid program expenditures, and may be limited in its accounting of State spending on unemployment. The commenter recommended that alternative measures be expressly made available in the rule and that Statewide GDP growth should be included as a valid, alternative indicator of Statewide economic distress, as should a State's unemployment rates.

Response: We acknowledge that a recession will affect States' revenue differently depending on the various revenue sources States use and how those sources respond to the economic conditions. We disagree that the use of the Federal Reserve Bank of Philadelphia to identify periods of economic distress is limited in its appropriateness for States that depend heavily on sales taxes.

We reviewed this issue by identifying 9 States whose budgets rely heavily on sales taxes and 8 States whose budgets rely heavily on income taxes. We performed an analysis using the Federal Reserve Bank of Philadelphia State coincident index to see if we could determine a difference in States qualifying for an economic distress repayment schedule based on their tax revenue sources. Our analysis did not show a significant difference in qualifying for an alternate repayment schedule between States that rely heavily on general sales tax and those that rely heavily on income taxes.

We also contacted various sources to obtain an understanding of how a State's revenue based on general sales tax will be affected by a recession. Our sources provided a general overview of the effect of State tax revenue during a recession stating that income tax is often more volatile than sales tax. In some States, the sales tax may also be volatile. Most States rely on both a sales and an income tax, which makes up less than one-third of the total taxes. Therefore, there will not necessarily be a significant difference during a recession.

We believe that the use of the Federal Reserve Bank of Philadelphia State coincident index is the best indicator of a State's monthly fiscal health. We note that the trend for each State's index is set to the trend of its GPD and that the data used in determining the index is the best approximation of the type of information used to determine a national recession. We believe that the Federal Reserve Bank of Philadelphia provides for a more equitable treatment of States, is 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 note the commenter's assertion that there are other indicators that may provide a more accurate determination of a State's fiscal health and that these indicators are not measured by the Federal Reserve Bank of Philadelphia. We conducted research and analyzed several potential economic distress measures before making our determination to use the Federal Reserve Bank of Philadelphia. Each measure has some advantages and disadvantages. We found that this is the best option for determining economic distress on a State-by-State basis. It also met the criteria that we believe will best serve States and CMS in making a determination.

Comment: One commenter has concerns that this rule will institutionalize a data series produced by a private entity.

Response: The Philadelphia Federal Reserve Bank is one of the 12 regional Reserve Banks that, together with the Board of Governors in Washington, DC, make up the Federal Reserve System. It is headquartered in Philadelphia, Pennsylvania and is responsible for the Third Federal Reserve District.

The Federal Reserve Banks have been operating since November 16, 1914. The Federal Reserve Banks' structure consists of both the public or government sector and the private sector. The public sector is represented by a Board of Governors appointed by the President of the United States and confirmed by the U.S. Senate. The private sector is represented by a board of directors. We are confident in relying on data produced by an entity that is part of the Federal Reserve System.

Therefore, we are finalizing without change our proposal to 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 as stated in the proposed rule.

D. Refunding of Federal Share of Overpayments to Providers

We proposed to revise § 433.300 through § 433.322 in accordance with section 6506 of 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, unless the overpayment is due to fraud. At the end of the 1-year period, the State is required to return to the Federal government the Federal share of any overpayment not yet returned.

For a detailed description of these provisions, please refer to the proposed rule (76 FR 46691).

The following is a summary of the comments we received regarding refunding of Federal share of overpayments to providers.

Comment: One commenter expressed concern regarding the definition of ''final written notice'' in § 433.304. The commenter stated that the proposed changes to sections 433.304 and 433.316 could have the effect of binding the State Medicaid agency to actions taken by other State officials, and suggested some examples of potential problems that could arise, in practice, in situations where the State Medicaid agency does not have legal control over other State officials. The commenter recommended that the proposed regulation be amended to clarify that a State Medicaid agency may not be expected to repay FFP on the basis of allegations made against a provider or filed under authority of another State official. The commenter also recommended that the ''final written notice'' may only come from a State Medicaid agency official.

Response: The State Medicaid agency is responsible for returning the Federal share of an overpayment based upon the amount discovered, which, for purposes of § 433.316(d), is the amount identified in the final written notice, as defined in § 433.304. Although we understand the commenter's concern that the State Medicaid agency may not have control over the overpayment determination stated in the final written notice, the only way a State Medicaid agency may treat an overpayment as resulting from fraud under § 433.316(d) is for a law enforcement entity, for example, a Medicaid Fraud Control Unit (MFCU) to accept the case based on a referral from the State Medicaid agency, or for the law enforcement agency to file a civil or criminal case against a provider and notify the State Medicaid agency. There are likely to be instances when other State officials will take action in a State and provide notice to the State Medicaid agency. In those instances, the State Medicaid agency is ultimately responsible for returning the Federal share of the overpayment. Therefore, we decline to take the commenter's recommendations and amend the definition of ''final written notice.''

Comment: One commenter stated that the purpose of § 433.316 appears to ensure that the State Medicaid agency makes referrals to the MFCU when there is evidence of fraud. The commenter stated that in general, that expectation is reasonable, but a referral to a MFCU may be redundant in situations where the State Medicaid agency is first made aware of a fraud case because a criminal prosecution has already been initiated by the MFCU, a local prosecuting attorney, or through the U.S. Attorney's office.

Response: Although it is true that MFCUs often develop their own cases, we encourage State Medicaid agencies and MFCUs to maintain open communications to keep all parties informed of the cases being worked by each of the offices. Referral of a case developed only by a MFCU back to the MFCU by the State Medicaid agency is not required by § 433.316. However, where the parties independently develop the same case, under § 433.316(d)(3), for the State Medicaid agency to be able to consider the overpayment as resulting from fraud, either (1) the State Medicaid agency must refer the case to the MFCU or other appropriate law enforcement agency and receive a written notification of acceptance of the case from the MFCU or other appropriate law enforcement agency; or (2) the MFCU or other appropriate law enforcement agency must file a civil or criminal case against a provider and notify the State Medicaid agency. In the event the State Medicaid agency identifies allegations of fraud it determines are credible, it is required under § 455.23 to refer the matter to the MFCU and suspend payments, unless good cause exceptions apply, even if the MFCU has developed the case independently.

Comment: One commenter noted that a State Medicaid agency may already have commenced or concluded reasonable collection efforts under other procedures, for example, a provider that is associated with a criminal fraud case may also be associated with a bankruptcy case. The commenter recommended that a State be permitted discretion to pursue the most viable collection strategy.

Response: Where a State Medicaid agency has commenced or concluded reasonable collection efforts under other procedures, we do not believe that utilizing the fraud exception under § 433.316(d) is necessary. The State Medicaid agency has the discretion to pursue whichever collection strategy it deems most viable; however, the extended period for returning the Federal share under § 433.316 may or may not apply to the extent that the selected collection strategy does not

lead the MFCU or appropriate law enforcement agency to file a civil or criminal action against a provider as referred to in § 433.316(d)(3).

Comment: One commenter recommended that CMS clarify that the existence of an element of fraud in a case of an overpayment does not preclude a State from relying on other regulations such as bankruptcy or out of business exceptions to relieve a State of its obligation to repay FFP.

Response: Under § 433.318, a State Medicaid agency will not be required to repay the Federal share of a discovered overpayment if a provider is determined to be bankrupt or out of business in accordance with § 433.318. As clarification, whether the provider's overpayment was a result of fraud is not material to the question of whether the State may rely upon § 433.318. The existence of fraud does not extend the time period within which the provider may file its bankruptcy petition or for the State Medicaid agency to determine the provider is out of business.

Comment: One commenter requested clarification on the use of bankruptcy terminology in § 433.318(c)(1) and § 433.318(e) of the rule. The commenter noted that there is a distinction between a voluntary bankruptcy petition filed by the debtor and an involuntary bankruptcy petition filed by a creditor. The commenter noted that this rule does not seem to fully describe the bankruptcy process and the variety of possible related outcomes. The commenter suggested that the language in the rule (''if the State recovers an overpayment amount under a court-approved discharge of bankruptcy'') suggests that a State will actually recover an overpayment amount through this process, which is a possible outcome, but unlikely to occur in practice. The commenter also suggests that the phrase ''discharge of bankruptcy'' is unclear and asks if the phrase is intended to convey a discharge of debt, or a discharge of a debtor. The commenter suggests that the phrase ''if a bankruptcy petition is denied, the agency must refund the Federal share of the overpayment in accordance with the procedures * * *'' appears to be problematic noting that it was probably intended to mean that the Medicaid provider, now a debtor, has been denied a discharge of debt. The commenter also suggested that it should be afforded discretion to tailor the collection process and strategy to the facts in the case and that if a State follows reasonable collection procedures; it should not be required to refund the Federal share. The commenter recommends that § 433.318 be modified to reflect the most likely possible outcomes in bankruptcy cases and that a State should not be required to refund the Federal share of an overpayment in cases where a debt is uncollectible. They suggested that the determination should be based on whether a debt is collectible, and not on whether a formal discharge of debt has been granted.

Response: We appreciate the comments, but note that the comments are outside the scope of this rule. We revised the overpayment regulations to bring them into compliance with section 6506 of the Affordable Care Act, which 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. Therefore, we decline the commenter's recommendations to make clarifications on the use of bankruptcy terminology. We will consider these comments with respect to possible future rulemaking.

Comment: One commenter sought clarification on whether States will be required to submit individualized documentation of reasonable collection efforts to make reclamation and believed that such a requirement will be administratively burdensome, and requested that CMS consider ways to minimize this documentation burden.

Response: The submission of documentation for reclaiming of refunds is addressed in regulations. Current regulations at § 433.320(g) state that if the agency reclaims a refund of the Federal share of an overpayment in cases of bankruptcy, the agency must submit to CMS a statement of its efforts to recover the overpayment during the period before the petition for bankruptcy was filed. In cases of out-of-business providers, the agency must submit to CMS a statement of its efforts to locate the provider and its assets and to recover the overpayment during any period before the provider is found to be out-of-business in accordance with § 433.318. This rule did not revise any of the requirements for a State to document that it made reasonable efforts to obtain recovery. Since the overpayment rule was published in 1989, we have not been made aware of any administrative burden that has been imposed on States. We appreciate the comment, but we do not see a need to revise the documentation requirement.

Therefore, we are finalizing without change our proposal to revise § 433.300 through § 433.322 in accordance with section 6506 of the Affordable Care Act as stated in the proposed rule.

E. Technical Corrections to Medicaid Regulations

1. Grants Procedures

This 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 final rule to make the correction. States are currently using the CMS–37 form.

2. Deferral of Claims for FFP

This final rule will revise the language in the delegation of authority for deferral determinations under § 430.40 and for disallowance determinations under § 430.42 to reflect the term ''Administrator or current Designee.'' This revision will ensure that future changes in the internal structure of CMS will not affect the authority of the Regional Office to impose deferral and disallowance of claims for FFP.

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

We proposed 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

This final rule corrects 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.

We did not receive any comments pertinent to these provisions. Therefore, we are finalizing without change these provisions as stated in the proposed rule.

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 proposed 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).

We did not receive any comments pertinent to these provisions. Therefore, we are finalizing without change these provisions as stated in the proposed rule.

G. General Comments

Comment: One commenter expressed thanks for the codification of the administrative reconsideration process, for increasing the time available to States to notify CMS of their intent, and for lowering the threshold level to qualify for a repayment by installments.

Response: We appreciate the support for this rule.

Comment: One commenter expressed appreciation for CMS' support of States' program integrity efforts and believes that this rule addresses the need to streamline certain administrative processes related to disallowances, which could lead to administrative cost efficiencies for States and the Federal government. The commenter agreed with the agency that this new administrative reconsideration process could help minimize the administrative burden and allow States to quickly identify and rectify blatant errors in disallowance determinations.

The commenter also agreed that States should retain the authority to seek a formal adjudication by the Health and Human Services' Departmental Appeals Board.

The commenter also stated support for the proposal to determine economic distress on a State-by-State basis rather than relying solely on a national indicator because since the causes and timing of economic distress and recovery vary dramatically by State.

The commenter noted that the proposed change to § 433.320 aligns the Federal regulation with the requirements of the Affordable Care Act and provides State Medicaid agencies with the clarity needed to pursue overpayments to providers due to fraud. The commenter stated that State Medicaid directors are committed to working with Federal policymakers to improve program integrity tools and ensure States are not penalized for their diligent work in pursuing waste, fraud, and abuse.

Response: We appreciate the commenter's support for this rule.

Comment: One commenter noted inconsistency in the proposed rules regarding the change from ''Regional Administrator'' to ''Consortium Administrator.''

Response: We have revised the final rule to remove staff titles from the regulations for deferral determinations under § 430.40 and for disallowance determinations under § 430.42. Specifically, we have revised the language in these sections to reflect the term ''Administrator or current Designee.''

III. Provisions of the Final Regulations

As a result of our review of the comments we received during the public comment period, as discussed in section II. of this preamble, we are finalizing the proposed revisions as outlined in the proposed rule with the following exception:

We are revising § 430.40(c)(4) to make the language consistent throughout the proposed rule. The regulation has been revised to change the language in the delegation of authority for deferral determinations under § 430.40 and for disallowance determinations under § 430.42 to reflect the term ''Administrator or current Designee.''

IV. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995 (PRA), we are required to provide 30-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. 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.

All of the information collection requirements contained in this document are either exempt from the PRA or are currently approved under a valid OMB control number. Therefore, while we are not submitting any information collection requests to OMB for review and approval, we will consider public comments we may receive on these 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 will be collected subsequent to an administrative action, that is, a determination to disallow.

B. ICRs Regarding the Maintenance of Records (§ 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 92.42.'' We are incorporating these through reference in § 457.628(a). Accordingly, it will 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 final rule will 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 final rule will not impose any new or revised reporting or recordkeeping requirements concerning CMS–64.

If you comment on the information collection and recordkeeping requirements identified above, please submit your comments to the Office of Information and Regulatory Affairs, Office of Management and Budget, Attention: CMS Desk Officer, 2292–F, Fax: (202) 395–6974; or Email: *OIRA_submission@omb.eop.gov*.

V. Regulatory Impact Statement

A. Statement of Need

This final rule implements changes to the following:

- 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 FFP under title XIX of the Act (Medicaid).
- 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.
- 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, for administrative review, unless inconsistent with the CHIP statute.
- 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.
- 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 the term ''Administrator or current Designee''; 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.

C. Anticipated Effects

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*).

The Secretary has also determined that this final rule will not have a significant economic impact on a substantial number of small entities.

In addition, section 1102(b) of the Act requires us to prepare a 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 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 for Medicare payment regulations and has fewer than 100 beds. We did not prepare an analysis for section 1102(b) of the Act because the Secretary has determined that this final rule will not have a significant impact on the operations of a substantial number of small rural hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. In 2012, that threshold is approximately $139 million. This rule will 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.

Effects on State Medicaid Programs

The final 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. For a detailed description of the provisions of the proposed rule, please refer to the proposed rule (76 FR 46693).

D. Alternatives Considered

This section provides an overview of regulatory alternatives that we considered for the 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 which were in the proposed rule (76 FR 46694).

1. Administrative Review of Determinations To Disallow Claims for FFP

In the proposed rule (76 FR 46694), we set out procedures for States to request a reconsideration of a disallowance to the CMS Administrator. For a detailed description of the procedures considered, please refer to the proposed rule.

2. Repayment of Federal Funds by Installments

In the proposed rule (76 FR 46694), we proposed three schedules including schedules that recognize the unique fiscal pressures of States that are experiencing economic distress. For a detailed description of the schedules considered, please refer to the proposed rule.

E. Conclusion

For the reasons discussed above, we did not prepare analysis for either the RFA or section 1102(b) of the Act because we 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 amends 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).

■ 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 Departmental 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)(4), (c)(5), (c)(6), and (e)(1) to read as follows:

§ 430.40 Deferral of claims for FFP.

(a) * * *

(1) The Administrator or current Designee questions its allowability and needs additional information to resolve the question; and

* * * * *

(b) * * *

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

* * * * *

(c) * * *

(3) If the current Designee 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.

(4) If the State does not provide the necessary materials within 15 days, the current Designee disallows the claim.

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

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

* * * * *

(e) * * *

(1) The Administrator or current Designee 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 Administrator or current Designee 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 a disallowance.* (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 Regional Office.

(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 Regional Office.

(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 paragraph (c)(3) of this section.

(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 Regional Office 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 Regional Office, 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 appeal a disallowance to 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 appeals 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 Regional Office 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 will 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 will 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).

■ 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 Regional Office in writing of its decision to do so.

(2) The agency must mail its notice to the CMS Regional Office 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 request for 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.

* * * * *

■ 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 § 433.316, ends.

* * * * *

(4) If the State does not refund the Federal share of such overpayment as indicated in paragraph (a)(2) of this section, 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).

§ 447.272 [Amended]

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

■ 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.

* * * * *

§ 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).

§ 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.

■ 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.

* * * * *

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

Dated: April 18, 2012.

Marilyn Tavenner,

Acting Administrator, Centers for Medicare & Medicaid Services.

Approved: May 8, 2012.

Kathleen Sebelius,

Secretary, Department of Health and Human Services.

[FR Doc. 2012–12637 Filed 5–25–12; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

45 CFR Parts 155, 156, and 157

[CMS–9989–CN]

RIN 0938–AQ67

Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers; Correction

AGENCY: Department of Health and Human Services.

ACTION: Final rule; correction.

SUMMARY: This document corrects technical and typographical errors that appeared in the final rule, interim final rule, published in the **Federal Register** on March 27, 2012, entitled ''Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers.''

DATES: *Effective Date:* These corrections are effective on May 29, 2012.

FOR FURTHER INFORMATION CONTACT: Alissa DeBoy, (301) 492–4428.

SUPPLEMENTARY INFORMATION:

I. Background

In FR Doc. 2012–6125 of March 27, 2012, (77 FR 18310) there were technical and typographical errors that are identified and corrected in the ''Correction of Errors'' section below. The provisions in this correction notice are effective as if they had been included in the document published on March 27, 2012. Accordingly, the corrections are effective on May 29, 2012.

II. Summary of Errors

On page 18327, in the preamble discussion of standards for consumer assistance tools, there are errors in references to the regulations text. The cross references to § 155.200(a) and § 155.200(b) are incorrect, and are being corrected to read § 155.205(a) and § 155.205(b), respectively, which are the provisions discussing the Exchange call center and Web site.

On page 18331, the preamble explains that Exchanges cannot require Navigators to have agent and broker licenses. However, one sentence implies that any licensure standards for Navigators would cause Navigators to be agents and brokers, which is inaccurate. The sentence also incorrectly implies that establishing any licensure standards would not be allowed, which would conflict with § 155.210(c)(1)(iii). Therefore, we are adding the word ''such'' to the following sentence to refer specifically to agent and broker licensure. We are also adding the word ''in,'' immediately preceding the citation, which was accidentally omitted before. The revised sentence will read as follows: ''Thus, establishing such licensure standards for Navigators would mean that all Navigators would be agents and brokers, and would violate the standard set forth in § 155.210(c)(2) of the final rule that at least two types of entities must serve as Navigators.''

On page 18336, the preamble discusses the potential for future standards related electronic notices and coordination of notices between Medicaid, CHIP, and the Exchanges. We indicate that future rulemaking will be issued for these standards. We are correcting these references to state that future guidance will be released to provide more information on electronic notices and notices coordination.

On page 18341, in preamble discussion of privacy and security standards, we are correcting two errors. First, the definition of personally identifiable information in § 155.260(a) of the proposed rule published on July 15, 2011, was not included in the final rule in order to align the definition with a memorandum released by the Office of Management and Budget. In the preamble, the cross reference to § 155.260(a), which does not exist in the final rule, is replaced with ''as defined in the Office of Management and Budget Memorandum M–07–16.''

Second, on page 18341, the preamble uses the term ''personally identifiable health information.'' The privacy and security section of the final rule applies to ''personally identifiable information.'' Personally identifiable health information is a subset of this term, and is not the focus of the rule, as stated in the preamble. The word ''health'' was