DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 401

[CMS–6032–P]

RIN 0938–AO27

Medicare Program; Use of Repayment Plans

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

ACTION: Proposed rule.

SUMMARY: This proposed rule would modify Medicare regulations to implement a provision of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 pertaining to the use of repayment plans (also known as extended repayment schedules or ''ERS''). Under this provision, we propose to grant a provider or a supplier an extended repayment schedule under certain terms and conditions as defined in the statute. The proposed rule would establish criteria and procedures to apply this requirement and to define the concepts of ''hardship'' and ''extreme hardship.''

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on January 26, 2007.

ADDRESSES: In commenting, please refer to file code CMS–6032–P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

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

1. *Electronically.* You may submit electronic comments on specific issues in this regulation to *http://www.cms.hhs.gov/eRulemaking.* Click on the link ''Submit electronic comments on CMS regulations with an open comment period.'' (Attachments should be in Microsoft Word, WordPerfect, or Excel; however, we prefer Microsoft Word.)

2. *By regular mail.* You may mail written comments (one original and two copies) to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–6032–P, P.O. Box 8020, Baltimore, MD 21244–8032.

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

3. *By express or overnight mail.* You may send written comments (one original and two copies) to the following address only: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–6032–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

4. *By hand or courier.* If you prefer, you may deliver (by hand or courier) your written comments (one original and two copies) before the close of the comment period to one of the following addresses. If you intend to deliver your comments to the Baltimore address, please call telephone number (410) 786–7195 in advance to schedule your arrival with one of our staff members. Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201; or 7500 Security Boulevard, Baltimore, MD 21244–1850. (Because access to the interior of the HHH Building is not readily available to persons without Federal Government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

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

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

FOR FURTHER INFORMATION CONTACT: Tom Noplock, (410) 786–3378.

SUPPLEMENTARY INFORMATION:

Submitting Comments: We welcome comments from the public on all issues set forth in this rule to assist us in fully considering issues and developing policies. You can assist us by referencing the file code, CMS–6032–P, and the specific ''issue identifier'' that precedes the section on which you choose to comment.

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following Web site as soon as possible after they have been received: *http://www.cms.hhs.gov/eRulemaking.* Click on the link ''Electronic Comments on CMS Regulations'' on that Web site to view public comments.

Comments received timely will also be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1–800–743–3951.

I. Background

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

A. Medicare Overpayment

Medicare overpayments are Medicare funds an individual, provider, or supplier has received that exceed amounts due and payable under the Medicare statute and regulations (plus any applicable interest and penalties assessed on the overpayment). We note that Medicare regulations at 42 CFR 400.202 define a ''supplier'' as ''a physician or other practitioner, or an entity other than a provider, that furnishes health care services under Medicare.''

Generally, overpayments result when payment is made by Medicare for noncovered items or services that exceeds the amount allowed by Medicare for an item or service, or when payment is made for items or services that should have been paid by another insurer (Medicare secondary payer obligations). Once a determination and any necessary adjustments in the amount of the overpayment have been made, the remaining amount is a debt owed to the United States Government.

Section 1870 of the Social Security Act (the Act) provides a framework within which liability for such Medicare overpayments is determined and recoupment of overpayments is pursued. This framework prescribes a decision making process that the agency follows when pursuing the recoupment of Medicare overpayments.

The regulation governing the liability for Medicare overpayments is located at 42 CFR part 401 (subpart F).

B. Statutory Authority

The Federal Claims Collection Act (FCCA) of 1966, Public Law 89–508, 80 Stat. 308 (1966) (amended by the Debt Collection Improvement Act of 1966, Pub. L. 104–134 (1996) (codified at 31 U.S.C. 3711) is the Federal government's basic statutory authority for debt management practices. The Congress intended the FCCA to reduce the amount of litigation previously required to collect claims and to reduce the volume of private relief legislation in

the Congress. The FCCA is independent of the other authorities we use to collect debt and was intended by the Congress to add to, rather than to supplant, other authorities, including common law authority.

The FCCA authorizes the head of an agency to collect claims in any amount. This statute also provides that the head of an agency may, under certain conditions, compromise a claim, or suspend or terminate collection action on a claim. Uncollectible claims in excess of $100,000, exclusive of interest, must be referred to the Department of Justice for compromise.

On November 2, 1977, the Secretary of the Department of Health and Human Services published a rule in the **Federal Register** (42 FR 57351) to delegate authority to the Department Claims Officer generally, and the Administrator of the Centers for Medicare & Medicaid Services (formerly Health Care Financing Administration (HCFA)) for necessary claims collection actions under our programs. The authority delegated to the Administrator covers all of our activities in the Medicare program (title XVIII) and pertains to claims up to $20,000. (This amount has been increased to $100,000; see 31 U.S.C. 3711.)

On August 29, 1983, we published a final rule with comment period titled ''Federal Claims Collection Act; Claims Collection and Compromise'' in the **Federal Register** (48 FR 39060) in accordance with the FCCA. In this final rule, the agency adopted the applicable debt collection tools made available to it under the FCCA including the ability to collect or compromise claims, or suspend or terminate collection action, as appropriate. The final rule also set forth the requirements we would use to evaluate debtors' requests for extended repayment agreements specified in § 401.607.

As part of the Health Insurance Portability and Accountability Act of 1996, the Congress added section 1893 to the Act establishing the Medicare integrity program (MIP) to carry out Medicare program integrity activities that are funded from the Medicare Trust Fund. Section 1893 of the Act expands our contracting authority to allow us to contract with ''eligible entities'' to perform Medicare program integrity activities. These activities include review of provider and supplier activities, including medical, fraud, and utilization review; cost report audits; Medicare secondary payer determinations; education of providers, suppliers, beneficiaries, and other persons regarding payment integrity and benefit quality assurance issues; and developing and updating a list of durable medical equipment items that are subject to prior authorization (42 U.S.C. 1395ddd). These MIP contractors assist us in the identification and collection of provider and supplier Medicare overpayments.

Overview of Current Policy

The current policy CMS and its contractors use for the evaluation of extended repayment schedules (ERSs) is based on the existing regulations at § 401.607(c)(2) [which we are proposing to redesignate as § 401.607(c)(3)] and guidance in the Medicare Financial Management Manual, Pub. 100–6 (Chapter 4, Section 50). Under our current policy, we determine the frequency and amount of the installment payments based on the factors set forth at § 401.607(c)(2) which include: (i) The amount of the claim; (ii) the debtor's ability to pay; and (iii) the cost to CMS of administering an installment agreement.

Under the current ERS review process, we primarily focus on the second factor, the debtor's ability to repay the overpayment, by conducting a review of the debtor's financial status, similar to how banks assess applicants for a loan. In almost all cases, we try to work with the provider or supplier to recover the overpayment. In general, it has been our experience that it is in both CMS and the debtor's best interests to work out a reasonable repayment schedule to recoup an overpayment rather than demand immediate collection of the debt, which could place a provider or supplier at financial risk or force the provider or supplier into bankruptcy.

Under our existing procedures we review financial documentation submitted by the provider or supplier to assess the provider's or supplier's ability to repay the Medicare overpayment. This documentation must include, at a minimum, a statement of financial position (for example, balance sheet), a statement of financial performance (for example, income statement), and a statement of future viability (for example, projected statement of cash flow). In addition, the provider must include a letter from a financial institution proving that it cannot obtain financing from an alternative source.

C. Medicare Prescription Drug, Improvement, and Modernization Act of 2003

1. Hardship Provision

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

On December 8, 2003, the Congress enacted the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 (Pub. L. 108–173). This new legislation contained provisions affecting the recovery of provider and supplier overpayments under the Medicare program. Section 935(a) of the MMA amended title XVIII of the Act by adding a new section 1893(f)(1) to the Act to require us to use certain statutory criteria in evaluating whether a provider or supplier should be granted a repayment schedule of at least 6 months and up to 5 years. Under section 1893(f)(1) of the Act, we may grant a provider or a supplier upon request, a repayment schedule of at least 6 months, if repaying an overpayment within 30 days would constitute a ''hardship'' on the provider or supplier, provided that certain criteria are met.

The new statute at section 1893(f)(1)(B)(i) of the Act defines ''hardship'' based on the relationship between the amount of the overpayment(s) not covered under an existing ERS owed by a provider or supplier and the total amount of Medicare payments made to that provider or supplier over the most recently submitted cost report or for the previous calendar year.

Under section 1893(f)(1)(B) of the Act, a provider or supplier is deemed to be in ''hardship'' when the total amount of all outstanding overpayments not included in an approved, existing repayment schedule, is 10 percent or greater than the total Medicare payments made for the cost reporting period covered by the most recently submitted cost report (for a provider filing a cost report), or the previous calendar year (for a supplier or non cost-report provider). We propose to interpret ''outstanding overpayments'' to include both principal and accrued interest. We read the newly added section 1893(f)(1)(B)(iii) of the Act to exclude overpayments already being repaid under an approved ERS.

We propose to interpret the new ''hardship'' test under section 935(a) of the MMA as not to supersede our extended repayment schedule regulations currently at § 401.607(c)(2), (which we are proposing to redesignate as § 401.607(c)(3) in this proposed rule). Since our existing regulations governing ERSs are promulgated under the FCCA, we do not plan to eliminate the criteria and procedures currently used to grant providers and suppliers ERSs. Instead, we propose adding an initial ''hardship'' test to existing regulations and

procedures for determining a debtor's ERS.

We are proposing that all requests for an ERS first be evaluated under the new ''hardship'' test. Under this MMA provision, if ''hardship'' is determined and no statutory exception applies under § 401.607(c)(2)(iv), then the statute requires that the Secretary grant a provider or supplier a repayment period of at least 6 months but not longer than 3 years.

Section 935(a) of the MMA requires that the Secretary establish rules for cases when a provider or a supplier was not paid during the previous year or paid for only a portion of that year. For these cases, we propose using the last 12 months of Medicare payments made to the provider or supplier. In cases where there is less than a 12-month payment history, we propose that the number of months available be annualized to equal an approximate yearly Medicare payment level for the provider or supplier.

Using the new ''hardship'' test provided in section 1893(f)(1) of the Act, the contractor would calculate ''hardship'' as described in the following examples:

If the debt is from a provider that files cost reports, then the contractor will—

Step 1: Determine cost reporting year covered by most recently filed cost report;

Step 2: Determine total amount of Medicare dollars paid to provider for that cost report year;

Step 3: Determine amount of all outstanding overpayments (principal and accrued interest) not under an existing ERS; and

Step 4: Divide result in Step 3 by result in Step 2.

If result in Step 4 is .10 or greater, then the provider meets the ''hardship'' test.

We note that Medicare dollars paid for providers that file cost reports include all interim payments including tentative settlement amounts.

Example: The provider submits cost report on 05/31/2004 for the cost report year from 01/01/2003 through 12/31/2003. For the cost report year ending 12/31/2003, the provider was paid a total of $1,000,000. On 8/31/2004, a notice of program reimbursement is issued as a result of the final settlement for the cost report year ending 12/31/2002 showing an overpayment of $105,000. Therefore, the provider meets the ''hardship'' test: $105,000 divided by $1,000,000 = .105. (Calculations should be carried out to three decimal points.)

If the debt is from a provider or supplier that does not file cost reports, then the contractor will—

Divide amount of all outstanding overpayments (principal and accrued interest) not under an existing ERS by the Medicare dollars paid by the contractor to the provider or supplier for the previous calendar year. If result is .10 or greater, the provider or supplier meets the ''hardship'' test.

Example: On 09/01/2004, the provider or supplier is issued a demand letter for overpayments resulting from Medical Review of Part A Claims that total $110,000. For calendar year 2003, the provider or supplier was paid $1,000,000 by Medicare. $110,000 divided by $1,000,000 = 11. Based on this calculation, the provider or supplier meets the ''hardship'' test.

If the provider or supplier does not qualify under the ''hardship'' test, we would then analyze the ERS request under the existing ERS procedures, found at newly redesignated § 401.607(c)(3).

2. Exceptions Under the ''Hardship'' Provision in Section 935(a) of the MMA

As stated above, section 935(a) of the MMA sets out exceptions to granting a provider or supplier an extended repayment schedule even if the provider or supplier meets the ''hardship'' test. These exceptions are when there is reason to suspect the provider or supplier may file for bankruptcy, cease to do business, discontinue participation in the program, or when there is an indication of fraud or abuse committed against the program. We propose that contractors continue to use existing procedures and definitions applicable to bankruptcy and fraud or abuse.

3. Extreme Hardship Provision

[If you choose to comment on issues in this section, please include the caption ''EXTREME HARDSHIP PROVISION'' at the beginning of your comments.]

Under section 935(a) of the MMA, the Secretary may grant a provider or a supplier a repayment schedule of 36 months and up to 60 months if repaying an overpayment would constitute an ''extreme hardship'' unless a statutory exception applies under § 401.607(c)(2)(iv). Since the Congress left the definition of ''extreme hardship'' to our discretion, we are considering different approaches for defining ''extreme hardship'' and seek public comment on this section.

We considered proposing a new financial threshold to determine if a provider or supplier was in extreme financial hardship, such as using a 15 percent threshold. We rejected this approach because it could result in discriminating against providers and suppliers who may be similarly financially situated but may attribute more of their total revenue to Medicare income. This could occur for example with a home health agency (HHA) which may attribute 100 percent of its revenue to Medicare business and a skilled nursing facility (SNF) which may only attribute 20 percent of its business to Medicare. The following example may help illustrate the inequitable results that may occur. If a HHA reporting $1 million in total revenue (100 percent of which was attributed to Medicare income), was subject to a 15 percent extreme hardship test, the HHA would need to owe an overpayment of 15 percent of $1 million, or at least $150,000, to qualify as being in extreme hardship. However, if a SNF reporting $1 million in total revenue had only 20 percent of its income attributed to Medicare ($200,000), this SNF would need to owe an overpayment of 15 percent of $200,000, or at least $30,000, in order to qualify as being in extreme hardship. This example illustrates the problems inherent with using a set threshold in defining ''extreme hardship'' for purposes of evaluating a provider's or supplier's ability to make payment on a Medicare debt. In fact, we believe that using any fixed financial variables in this type of evaluation poses limitations on CMS's ability to maintain the regulatory flexibility needed to properly evaluate a Medicare provider or supplier's request for an ERS. Using one fixed set of financial variables to determine the length of an ERS would be problematic and inefficient since the ERS evaluation is a multi-variable analysis. We need to review several variables contained in financial documents that include statements of a provider or supplier's financial position, financial performance, and future viability in order to properly assess a provider or debtor's ability to pay. Moreover, it is difficult for CMS to predict which financial variables will be the most useful in its analysis for each provider or supplier since this may vary on a case-by-case basis.

We propose to define ''extreme hardship'' when a provider or supplier qualifies under the ''hardship'' provision defined above and the provider's or supplier's request for an ERS is approved under newly redesignated § 401.607(c)(3). If we determine the request meets the criteria in newly redesignated § 401.607(c)(3) and meets the CMS manual guidance set forth in the Medicare Financial Management Manual, Pub. 100–6, Chapter 4, Section 50, the provider or supplier may be granted an ERS between 36 and 60 months. We are also proposing that contractors apply the

statutory exceptions to ''extreme hardship'' cases in a similar manner as they do to ''hardship'' cases. We solicit comments on other alternative approaches to define ''extreme hardship'' that could distinguish between the most extreme cases requiring ERSs between 36 and 60 months.

4. Extended Repayment Schedules

[If you choose to comment on issues in this section, please include the caption ''EXTENDED REPAYMENT SCHEDULES'' at the beginning of your comments.]

We propose to initially handle ERS requests differently than we have under our current regulations. The proposed rule would allow providers or suppliers that meet the ''hardship'' test and request only a 6-month ERS period, the opportunity to pay back the Medicare debt in 6 months without having to submit financial documentation to the contractor in accordance with the existing instructions given in the Medicare Financial Management Manual, CMS, Pub. 100–6, Chapter 4, Section 50. Not requiring financial documentation, such as financial statements, a bank denial letter, etc., may provide a provider or supplier time to generate or secure the necessary capital to liquidate the debt without having to file extensive documentation in order to secure a repayment schedule.

Under the proposed regulation, a provider or supplier that requests a 6-month repayment schedule, meets the ''hardship'' test, does not fall within an exception, and elects not to submit financial documentation would be approved for a 6-month repayment schedule. Any provider or supplier qualifying for the 6-month ERS under the ''hardship'' provision has the choice to turn down the 6-month ERS and either pay off the debt within 30 days of the date of determination or request a longer than 6-month ERS. In addition, we would not prohibit any provider or supplier under the 6-month ''hardship'' provision ERS from applying for a longer ERS if it later desires to do so under § 401.607(c)(3).

For all ERS requests, with the exception of those 6-month ERSs granted without a submission of financial documentation, we propose to rely on current regulations and procedures that require the provider or supplier to submit financial documentation in accordance with the Medicare Financial Management Manual, CMS Pub. 100–6, Chapter 4, Section 50. A provider or supplier must continue to submit a written request that refers to the specific overpayment for which an ERS is being requested, the number of months requested, and include the first payment with its request. The contractor would determine the duration of the ERS based on its review of the provider or supplier's documentation in accordance with CMS manual guidance.

While the statute permits us to immediately collect on an entire overpayment, if a provider or supplier misses one installment payment in any ERS granted under section 935(a) of the MMA, we are proposing to impose this penalty only on the automatic 6-month repayment schedules. With all other ERSs, we propose to continue to use the existing procedures that define a default of an ERS as missing two consecutive installment payments.

II. Provisions of the Proposed Regulations

[If you choose to comment on issues in this section, please include the caption ''PROVISIONS OF THE PROPOSED REGULATIONS'' at the beginning of your comments.]

We are proposing to revise paragraph (a) in § 401.601, *Basis and scope*, to read as follows: ''This subpart implements for CMS the Federal Claims Collection Act (FCCA) of 1966 (amended 1996) (31 U.S.C. 3711), and conforms to the regulations (31 CFR parts 900–904) issued jointly by the Department of the Treasury and the Department of Justice that generally prescribe claims collection standards and procedures under the FCCA for the Federal government. This subpart also implements section 1893(f)(1) of the Act regarding the use of repayment plans.''

In addition, we are proposing in § 401.603 to add a definition for an ''Extended repayment schedule.''

We are proposing to redesignate § 401.607(c)(2), ''CMS decision,'' as § 401.607(c)(3). In addition, we are proposing a new § 401.607(c)(2), ''Extended repayment schedule,'' in accordance with 1893(f)(1) of the Act. The provisions of section 1893(f)(1) of the Act, as amended by section 935(a) of the MMA, would be implemented by new § 401.607(c)(2), ''Extended repayment schedule.''

III. Collection of Information Requirements

This proposed rule does not impose any new information collection or recordkeeping requirements. The burden associated with the collection activities discussed in the preamble that pertain to the extension of repayment schedules is currently approved under Office of Management and Budget (OMB) control number 0938–0270, with an expiration date of September 30, 2007.

However, in addition to the requirements discussed in this proposed rule, we plan to submit a revised information collection request (ICR) to OMB for approval. As discussed in Section I.C.4. of the preamble, providers or suppliers that meet the ''hardship'' test and request only a 6-month ERS period, will have the opportunity to pay back the Medicare debt in 6 months without having to submit financial documentation to the contractor. This new requirement reduces the information collection burden placed on providers and suppliers. As part of the OMB approval process for the revised ICR, the revisions to 0938–0270 will be announced in **Federal Register** notices and made available to the public for comment.

IV. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

V. Regulatory Impact Statement

A. Overall Impact

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

Executive Order 12866 (as amended by Executive Order 13258, which merely reassigns responsibility of duties) directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). 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 would not reach the economic threshold and thus is not considered a major rule. There would be no additional costs or documented savings resulting from the implementation of

this rule. The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of $6 million to $29 million in any 1 year. For purposes of the RFA, approximately 95 percent of the health care industry is considered small businesses according to the Small Business Administration's size standards with total revenues of $6 million to $29 million or less in any 1 year. Individuals and States are not included in the definition of a small entity. Because there are no additional costs or documented savings resulting from the implementation of this rule, this rule would not have a significant impact on small businesses.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 100 beds. Because there are no additional costs or documented savings resulting from the implementation of this rule, this rule would not have a significant impact on small rural hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. That threshold level is currently approximately $120 million. This rule would not have an effect on the governments mentioned and the private sector costs would be less than $120 million threshold.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. This rule would not have a substantial effect on State or local governments.

B. Anticipated Effects

1. Effects on Medicare Providers

This rule could affect all Medicare provider types with a Medicare overpayment. This proposed rule would allow Medicare providers falling within these provisions a 6-month period to pay back debt owed to Medicare without being required to file extensive financial documentation. We believe that this short time period may permit a provider to generate or secure the necessary capital to liquidate the debt without filing the financial documentation required to secure a longer repayment schedule.

2. Effects on Other Providers

There would be no effect on other providers.

3. Effects on the Medicare and Medicaid Programs

There would be no additional costs or documented savings resulting from the implementation of this rule. There may be savings due to a possible reduction in paperwork.

C. Alternatives Considered

We considered adopting mathematically precise distinctions between ''hardship'' and ''extreme hardship,'' but rejected this approach. To select any type of numerical threshold, for example, defining ''extreme hardship'' as 15 percent of total overpayments in an effort to distinguish it from the test for ''hardship,'' would result in inequitable outcomes for different providers and suppliers as discussed in the ''extreme hardship'' section of the preamble. We believe the proposed approach will lead to more equitable solutions.

In implementing section 935 of the MMA, we want to assure providers and suppliers that we will be looking closely at the financial picture each of them has that has prompted them to seek an ERS. Analyzing these financial profiles is a complex undertaking that does not lend itself to overly simplified numerical cutoffs that may qualify some for longer repayment periods but deny them to others that ought to be just as eligible. We seek comment on other alternative ways to distinguish between ''hardship'' and ''extreme hardship'' in an effort to establish a standardized approach to applying the two definitions.

D. Executive Order 12866 Statement

In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

List of Subjects in 42 CFR Part 401

Claims, Freedom of information, Health facilities, Medicare, Privacy.

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

PART 401—GENERAL ADMINISTRATIVE REQUIREMENTS

1. The authority citation for part 401 continues to read as follows:

Authority: Secs. 1102, 1871, and 1893 of the Social Security Act (42 U.S.C. 1302, 1395hh, and 1395ddd). Subpart F is also issued under the authority of the Federal Claims Collection Act (amended 1996) (31 U.S.C. 3711).

2. In § 401.601, paragraph (a) is revised to read as follows:

§ 401.601 Basis and scope.

(a) *Basis.* This subpart implements for CMS the Federal Claims Collection Act (FCCA) of 1966 (amended 1996) (31 U.S.C. 3711), and conforms to the regulations (31 CFR parts 900–904) issued jointly by the Department of the Treasury and the Department of Justice that generally prescribe claims collection standards and procedures under the FCCA for the Federal government. This subpart also implements section 1893(f)(1) of the Act regarding the use of repayment plans.

* * * * *

3. In § 401.603, add a new definition for ''Extended repayment schedule'' to read as follows:

§ 401.603 Definitions.

* * * * *

Extended repayment schedule means installment payments to pay back a debt.

§ 401.607 [Amended]

4. In § 401.607—

A. Redesignate paragraph (c)(2) as paragraph (c)(3).

B. Add a new paragraph (c)(2).

The revisions read as follows:

§ 401.607 Claims collection.

* * * * *

(c) * * *

(2) *Extended repayment schedule.*

(i) For purposes of this paragraph (c)(2), the following definitions apply:

Hardship exists when the total amount of all outstanding overpayments (principal and interest) not included in an approved, existing repayment schedule is 10 percent or greater than the total Medicare payments made for the cost reporting period covered by the most recently submitted cost report for a provider filing a cost report, or for the

previous calendar year for a supplier or non cost-report provider.

Extreme hardship exists when a provider or supplier qualifies as being in ''hardship'' as defined in this paragraph and the provider's or supplier's request for an extended repayment schedule (ERS) is approved under paragraph (c)(3) of this section.

(ii) CMS or its contractor reviews a provider's or supplier's request for an ERS. For a provider or a supplier not paid by Medicare during the previous year or paid only during a portion of that year, the contractor or CMS will use the last 12 months of Medicare payments. If less than a 12-month payment history exists, the number of months available is annualized to equal an approximate yearly Medicare payment level for the provider or supplier.

(iii) For a provider or supplier requesting an ERS, CMS or its contractor evaluates the request based on the definitions and information submitted under this paragraph (c)(2). For a provider or supplier whose situation does not meet the definitions in paragraph (c)(2)(i) of this section, CMS or its contractor evaluates the ERS request using the information in paragraph (c)(3) of this section in deciding to grant an ERS.

(iv) CMS or its contractor is not required to grant an ERS to a provider or supplier if there is reason to suspect the provider or supplier may file for bankruptcy, cease to do business, discontinue participation in the Medicare program, or there is an indication of fraud or abuse committed against the Medicare program.

(v) CMS or its contractor may grant a provider or a supplier an ERS of at least 6 months if repaying an overpayment within 30 days would constitute a ''hardship'' as defined in paragraph (c)(2)(i) of this section. If a provider or supplier is granted an ERS for 6 months under paragraph (c)(2)(i) of this section, missing one installment payment constitutes a default and the total balance of the overpayment will be recovered immediately.

(vi) CMS or its contractor may grant a provider or a supplier an ERS of 36 months and up to 60 months if repaying an overpayment would constitute an ''extreme hardship'' as defined in paragraph (c)(2)(i) of this section.

* * * * *

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

Dated: April 5, 2006.

Mark B. McClellan,

Administrator, Centers for Medicare & Medicaid Services.

Approved: May 17, 2006.

Michael O. Leavitt,

Secretary.

Editorial Note: This document was received at the Office of the Federal Register on November 20, 2006.

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DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

50 CFR Part 648

RIN 0648–AT67

[Docket No.061109296–6296–01; I.D. 110606A]

Fisheries of the Northeastern United States; Atlantic Bluefish Fisheries; 2007 Atlantic Bluefish Specifications; 2007 Research Set-Aside Project

AGENCY: National Marine Fisheries Service (NMFS), National Oceanic and Atmospheric Administration (NOAA), Commerce.

ACTION: Proposed rule; request for comments.

SUMMARY: NMFS proposes 2007 specifications for the Atlantic bluefish fishery, including state-by-state commercial quotas, a recreational harvest limit, and recreational possession limits for Atlantic bluefish off the east coast of the United States. The intent of these specifications is to establish the allowable 2007 harvest levels and possession limits to attain the target fishing mortality rate (F), consistent with the stock rebuilding program in Amendment 1 to the Atlantic Bluefish Fishery Management Plan (FMP).

DATES: Written comments must be received no later than 5 p.m. eastern standard time, on December 27, 2006.

ADDRESSES: You may submit comments by any of the following methods:

• E-mail: *Bluespecs2007@noaa.gov*. Include in the subject line the following identifier: ''Comments on 2007 Bluefish Specifications.''

• Federal e-Rulemaking portal: *http://www.regulations.gov*.

• Mail: Patricia A. Kurkul, Regional Administrator, NMFS, Northeast Regional Office, One Blackburn Drive, Gloucester, MA 01930. Mark the outside of the envelope: ''Comments on 2007 Bluefish Specifications.''

• Fax: (978) 281–9135.

Copies of the specifications document, including the Environmental Assessment and Initial Regulatory Flexibility Analysis (EA/IRFA) and other supporting documents for the specifications are available from Daniel Furlong, Executive Director, Mid-Atlantic Fishery Management Council, Room 2115, Federal Building, 300 South Street, Dover, DE 19901–6790. The specifications document is also accessible via the Internet at *http://www.nero.noaa.gov*.

The Northeast Fisheries Science Center (Center) 41st Stock Assessment Review Committee (SARC) Bluefish Assessment Report (updated for 2006) is available at: *http://www.nefsc.noaa.gov/nefsc/publications/crd/crd0514/*.

FOR FURTHER INFORMATION CONTACT: Allison Ferreira, Fishery Policy Analyst, (978) 281–9103, or Michael Pentony, Senior Fishery Policy Analyst, (978) 281–9283.

SUPPLEMENTARY INFORMATION:

Background

The regulations implementing the Atlantic Bluefish Fishery Management Plan (FMP) are prepared by the Mid-Atlantic Fishery Management Council (Council) and appear at 50 CFR part 648, subparts A and J. Regulations requiring annual specifications are found at § 648.160. The management unit for bluefish (*Pomatomus saltatrix*) is U.S. waters of the western Atlantic Ocean.

The FMP requires that the Council recommend, on an annual basis, total allowable landings (TAL) for the fishery, consisting of a commercial quota and recreational harvest limit (RHL). A research set aside (RSA) quota is deducted from the bluefish TAL (after any applicable transfer) in an amount proportional to the percentage of the overall TAL as allocated to the commercial and recreational sectors. The annual review process for bluefish requires that the Council's Bluefish Monitoring Committee (Monitoring Committee) review and make recommendations based on the best available data including, but not limited to, commercial and recreational catch/landing statistics, current estimates of fishing mortality, stock abundance, discards for the recreational fishery, and juvenile recruitment. Based on the recommendations of the Monitoring Committee, the Council makes a recommendation to the Northeast Regional Administrator (RA). This FMP is a joint plan with the Atlantic States Marine Fisheries Commission (Commission); therefore, the