

site within 30 minutes to operate the bridge.

(6) During closing of the span, the channel traffic lights would change from flashing green to flashing red, the horn will sound twice, and an audio voice warning device will announce bridge movement, then two repeat blasts of the horn until the bridge is seated and locked down. When the bridge is seated and locked down to vessels, the channel traffic lights will flash red.

(7) During the open span movement, the channel traffic lights would flash red, the horn will sound twice, followed by a pause, and then five repeat blasts of the horn until the bridge is in the full open position to vessels. In the full open position to vessels, the bridge channel traffic lights will turn from flashing red to flashing green then an audio warning device will announce bridge movement by stating "Security, security, security, the Norfolk Southern #7 Railroad Bridge at mile 5.8 is open for river traffic".

(8) Operational information will be provided 24 hours a day on marine channel 13 and via telephone (757) 924-5320.

* * * * *

Dated: August 18, 2004,

Ben R. Thomason, III,

*Captain, U. S. Coast Guard, Acting
Commander, Fifth Coast Guard District.*

[FR Doc. 04-19564 Filed 8-26-04; 8:45 am]

BILLING CODE 4910-15-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 402

[CMS-6146-CN]

RIN 0938-AL53

Medicare Program; Revised Civil Money Penalties, Assessments, Exclusions, and Related Appeals Procedures

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

ACTION: Correction of proposed rule.

SUMMARY: This document corrects a technical error that appeared in the proposed rule published in the **Federal Register** on July 23, 2004 entitled "Medicare Program; Revised Civil Money Penalties, Assessments, Exclusions, and Related Appeals Procedures."

FOR FURTHER INFORMATION CONTACT: Joel Cohen, (410) 786-3349.

SUPPLEMENTARY INFORMATION:

I. Background

In FR Doc. 04-16791 of July 23, 2004 (69 FR 43956), there was a technical error that is identified and corrected in the Correction of Errors section below.

We inadvertently omitted the correct **ADDRESSES** section, which included the e-mail address for electronic comments. We are correcting this error by republishing the **ADDRESSES** section of the proposed rule.

II. Correction of Errors

In FR Doc. 04-16791 of July 23, 2004 (69 FR 43956), make the following correction:

1. On page 43956, in the third column; in the second paragraph, replace the **ADDRESSES** section with the following:

ADDRESSES: In commenting, please refer to file code CMS-6146-P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

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

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

2. *By mail.* You may mail written comments (one original and two copies) to the following address only:

Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-6146-P, P.O. Box 8013, Baltimore, MD 21244-8013.

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

3. *By hand or courier.* If you prefer, you may deliver (by hand or courier) your written comments (one original and two copies) before the close of the comment period to one of the following addresses. If you intend to deliver your comments to the Baltimore address, please call telephone number (410) 786-7197 in advance to schedule your arrival with one of our staff members.

Room 445-G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201; or 7500 Security Boulevard, Baltimore, MD 21244-1850.

(Because access to the interior of the HHH Building is not readily available to persons without Federal Government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main

lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

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

III. Waiver of Proposed Rulemaking

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** to provide a period for public comment before the provisions of a notice take effect. We can waive this procedure, however, if we find good cause that notice and comment procedure is impracticable, unnecessary, or contrary to the public interest and incorporate a statement of the finding and the reasons for it into the notice issued.

We find it unnecessary to undertake notice and comment rulemaking because this notice merely provides a technical correction to the regulation. Therefore, we find good cause to waive notice and comment procedures.

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

Dated: August 16, 2004.

Ann C. Agnew,

Executive Secretary to the Department.

[FR Doc. 04-19257 Filed 8-26-04; 8:45 am]

BILLING CODE 4120-01-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 431 and 457

[CMS-6026-P]

RIN 0938-AM86

Medicaid Program and State Children's Health Insurance Program (SCHIP): Payment Error Rate Measurement

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

ACTION: Proposed rule.

SUMMARY: This proposed rule would require State agencies to estimate improper payments in the Medicaid program and SCHIP program. The Improper Payments Information Act of 2002 requires Federal agencies to annually review and identify those programs and activities that may be susceptible to significant erroneous

payments, estimate the amount of improper payments and report those estimates to the Congress and, if necessary, submit a report on actions the agency is taking to reduce erroneous payments.

The intended effect and expected results of this proposed rule would be for States to produce improper payment estimates for their Medicaid and SCHIP programs and to identify existing and emerging vulnerabilities that can be addressed by the States through actions taken to reduce the rate of improper payments and produce a corresponding increase in program savings at both the State and Federal levels.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on September 27, 2004.

ADDRESSES: In commenting, please refer to file code CMS-6026-P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

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

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

2. *By mail.* You may mail written comments (one original and two copies) to the following address only:

Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-6026-P, P.O. Box 8017, Baltimore, MD 21244-8017.

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

3. *By hand or courier.* If you prefer, you may deliver (by hand or courier) your written comments (one original and two copies) before the close of the comment period to one of the following addresses. If you intend to deliver your comments to the Baltimore address, please call telephone number (410) 786-7195 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.

Submission of comments on paperwork requirements. You may submit comments on this document's paperwork requirements by mailing your comments to the addresses provided at the end of the "Collection of Information Requirements" section in this document.

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

FOR FURTHER INFORMATION CONTACT:

Christine Saxonis, (410) 786-3722.

Janet E. Reichert, (410) 786-4580.

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-6026-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. After the close of the comment period, CMS posts all electronic comments received before the close of the comment period on its public Web site. Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone (410) 786-7195.

I. Background

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

A. Legislative History

The Improper Payments Information Act of 2002 (Pub. L. 107-300, enacted on November 26, 2002) requires Federal agencies to annually review and identify those programs and activities that may

be susceptible to significant erroneous payments, estimate the amount of improper payments, and report those estimates to the Congress and, if necessary, submit a report on actions the agency is taking to reduce erroneous payments. Under the Improper Payments Information Act, "improper payment" is defined as (a) any payment made that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements; and (b) includes any payment to an ineligible recipient; any payment for an ineligible service; any duplicate payment; payments for services not received; and any payment that does not account for credit for applicable discounts. Under the statute, the term "payment" means any payment (including a commitment for future payment, such as a loan guarantee) that is (a) made by a Federal agency, a Federal contractor, or a governmental or other organization administering a Federal program or activity; and (b) derived from Federal funds or other Federal resources or that will be reimbursed from Federal funds or other Federal resources.

The law applies with respect to improper payments made in fiscal years after fiscal year (FY) 2002 and requires inclusion of improper payment estimates for fiscal years after FY 2003.

To comply with the Improper Payments Information Act, the Secretary must estimate improper payments made under Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP). We have been estimating improper payments in the Medicare program since 1996 as part of the annual Chief Financial Officer's audit conducted by the Office of Inspector General. However, no systematic means of measuring overall program payment errors at the State and national levels currently exists for Medicaid and SCHIP. Since the Medicaid and SCHIP programs are administered by State agencies according to each State's unique program characteristics, State involvement in estimating improper payments is necessary for the Secretary to comply with the provisions of the Improper Payments Information Act.

The Improper Payments Information Act directed the Office of Management and Budget (OMB) to provide subsequent guidance. OMB defines significant erroneous payments as annual erroneous payments in the program exceeding both 2.5 percent of program payments and \$10 million. For all programs and activities susceptible

to significant erroneous payments, Federal agencies shall determine an annual estimated amount of erroneous payments and, for those programs with erroneous payments exceeding \$10 million, identify the reasons the programs are at risk and put in place a plan to reduce them, including setting targets for future erroneous payment levels and a timeline by which the targets will be reached. In the report to the Congress, Federal agencies shall include the following:

- The estimate of the annual amount of erroneous payments.
- A discussion of the causes and actions taken to correct the causes.
- A discussion of the amount of actual erroneous payments the agency expects to recover.
- Limitations that prevent the agency from reducing the erroneous payment levels, that is, resources, or legal barriers.

1. The Medicaid Program

Title XIX of the Social Security Act (the Act) authorizes States to provide health care services to low-income individuals and families through the Medicaid program. The Medicaid program is funded through Federal/State partnership whereby the State sets its own eligibility standards, benefit packages, and payment rates within broad Federal guidelines. In FY 2002, Medicaid program expenditures for health care services alone were \$246 billion (not including administrative expenditures).

2. State Children's Health Insurance Program (SCHIP)

Title XXI of the Act authorizes States to initiate and expand the provision of child health assistance to uninsured, low-income children. Under title XXI, States may provide child health assistance primarily for obtaining health benefits coverage through the following:

- A separate child health program that meets the requirements specified under section 2103 of the Act; or
- Expansion of eligibility for benefits under the State's Medicaid plan under title XIX of the Act; or
- A combination of the two approaches.

SCHIP is jointly financed by the Federal and State governments and is administered by the States. Each State determines the design of its program, eligibility groups, benefit packages, payment levels for coverage, and administrative and operating procedures. SCHIP provides a capped amount of funds to States on a matching basis for Federal FYs 1998 through 2007. In 1997, the Congress

appropriated nearly \$40 billion over 10 years to help States expand health care coverage to uninsured children. Over 5.3 million children were enrolled in SCHIP nationwide in FY 2002.

B. Measuring Payment Accuracy in Medicaid and SCHIP

1. The Payment Accuracy Measurement (PAM) Project

In FY 2000, we developed the PAM project to explore the feasibility of developing a method to estimate improper payments for the Medicaid program in response to the Government Performance and Results Act of 1993 (GPRA), Public Law No. 103-62, (1993). We will refer to the method to estimate improper payments as Payment Error Rate Measurement (PERM) in this proposed rule. We will use the term PAM in this discussion to describe the research and development project that was the precursor to PERM.

The PAM model uses a claims-based sample and review methodology and has been designed to estimate a State-specific payment error rate that is within ± 3 percent of the true population error rate with 95 percent confidence. Moreover, through weighted aggregation, the State-specific estimates can be used to make national level improper payment estimates for the Medicaid and SCHIP programs.

In the first year of the PAM Project, nine States voluntarily tested methodologies intended to produce State-specific improper payment estimates. From these tested methodologies and best practices, from the nine States, we developed the PAM model both to produce a State-specific payment accuracy rate that is within ± 3 percent of the true population accuracy rate with 95 percent confidence and to provide us with both the uniformity and precision to estimate improper payments at the national level while maintaining sufficient flexibility to enable States to produce State-specific estimates. In the second year, the PAM model was modified to conform to the Improper Payments Information Act of 2002 by including improper payments attributable to underpayments, overpayments, and improper payments attributable to ineligible beneficiaries. Twelve States tested the PAM model in their Medicaid fee-for-service and managed care programs. The second year test identified problem areas that needed resolution, produced project time savers, administrative tips, and realistic cost estimates that helped us to refine the PAM model for the third year. In the third year, 27 States are testing the PAM

model; 11 States in Medicaid, 3 States in SCHIP, and 13 States in both programs. Each State will identify improper payments due to overpayments, underpayments, and payments made to ineligible persons in fee-for-service and/or managed care settings for both programs.

2. The Payment Error Rate Measurement Program (PERM)

Since each State's Medicaid and SCHIP programs are unique in their program characteristics, it is critical that States provide us with State-specific improper payment estimates under the PERM program so we can estimate improper payments at the national level for these programs. With the challenges States are facing due to budget constraints and staffing shortages, it is unlikely that all States would voluntarily implement the current PAM model even though Federal and State program savings would be realized as a result of actions taken by the States to address problem areas identified through the process of estimating improper payments. However, the Secretary is required by the Improper Payments Information Act of 2002 to annually review all programs and activities (including Medicaid and SCHIP) to determine whether these programs are susceptible to significant improper payments and, because of the differences in the Medicaid and SCHIP programs nationwide, we must rely on State-specific information in order to make this determination.

Current law at section 1102 of the Act authorizes the Secretary to establish regulations as may be necessary to the efficient administration of the Medicaid and SCHIP programs. Medicaid law at section 1902(a)(6) of the Act and SCHIP law at section 2107(b)(1) of the Act require States to provide information necessary for the Secretary to monitor program performance. Through these statutory provisions, this proposed rule would require States to provide the Secretary with the information needed to monitor program performance by:

- Measuring improper payments in the Medicaid and SCHIP programs; and
- Providing State level improper payment estimates to the Secretary for calculating a national level improper payment estimate.

We believe the basic PAM model being pilot tested by many States can be implemented nationwide under the PERM program. The PAM model would effectively provide all States with the method needed to produce State-specific improper payment estimates on which we can base the national improper payment estimates needed to

comply with the provisions of the Improper Payments Information Act of 2002.

II. Provisions of the Proposed Rule

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

This proposed rule would enable the Secretary to comply with the requirements under the Improper Payments Information Act by producing a national improper payment estimate for the Medicaid and SCHIP programs using the State-specific estimates reported by the States. This proposed rule would allow the Secretary to monitor State performance in administering the Medicaid and SCHIP programs and maintain an overview of Medicaid and SCHIP improper program expenditures in an efficient manner.

This proposed rule builds upon the PAM model and proposes requirements that States must meet to produce State-specific improper payment estimates and report those estimates to the Secretary for the purpose of computing a national improper payment estimate. We plan to release guidance addressing any immediate questions States may have after reviewing the provisions of the final regulations within 60 days of the effective date of the regulation followed by detailed instructions describing the methods and procedures for estimating the payment error rate as necessary. However, we formally invite States to comment on the specific information they will need to implement the PERM program before the final regulation is published. We also will be seeking ways to solicit State input regarding the guidance so that States will know how to prepare for program implementation. The provisions of this proposed rule would be set forth in a new 42 CFR (Code of Federal Regulations) part 431, subpart Q and in part 457, subpart G as follows:

Part 431—State Organization and General Administration

Subpart Q—Requirements for Estimating Improper Payments in Medicaid and SCHIP

Section 431.950 Purpose

This proposed rule would require States to estimate, on the annual October through September Federal fiscal year basis, annually total improper payments and produce payment error rates in Medicaid and SCHIP using the PERM methodology. This proposed rule also would require States to provide these estimates to CMS by June 1 of the following year for the

purpose of CMS reporting a national estimate of improper payments in those programs to OMB by November 15. This timeline will allow OMB to compile the information in the Department's Performance and Accountability Report to the Congress. In conducting medical records reviews and eligibility reviews, States must adhere to the requirements of protection of recipient rights including those in § 435.901 and § 435.902.

We propose a process for estimating improper payments in both Medicaid and SCHIP in each State and the District of Columbia annually. From these State-level estimates, a national estimate of improper payments in each program will also be estimated. We propose to exclude the Territories from these regulatory requirements because the funding for the Medicaid and SCHIP programs is minimal, is subject to specific limits on Federal financial participation for each Territory, and inclusion of improper payment estimates for the Territories' Medicaid and SCHIP programs in the PERM program would not have an impact on the national error rate estimates for these programs.

Following the initial estimation of the error rate and improper payments, the States would take actions to address problem areas that result in improper payments. Improvement will be tracked over time through the States' annual payment error estimates.

States must also submit an Annual PERM Report to CMS by June 1 following the previously completed sampling period. The report must list the errors which the State identified in its review (and identify which amounts were overpayments, underpayments, and payments for ineligible individuals/services), explain the causes of the errors and explain the actions it will take to address those errors and to reduce the level of improper payments.

State Plan Requirements: Review and Sample Procedures for Estimating Improper Payments in Medicaid and SCHIP

Section 431.954 Basis and Scope

The statutory bases for this subpart are sections 1102, 1902(a)(6), and 2107(b)(1) of the Act, which authorize the Secretary to make rules and regulations necessary to the efficient administration of the Medicaid and SCHIP programs and require States to provide information, as the Secretary may need, to monitor program performance.

In addition, this rule would support the Improper Payments Information Act

of 2002 which requires Federal agencies to—

- Review annually and identify those programs and activities that may be susceptible to significant erroneous payments;
- Estimate the amount of improper payments; and
- Report those estimates to the Congress and, if necessary, submit a report on actions the agency is taking to reduce erroneous payments.

This proposed rule would require States under the current statutory provisions as stated in paragraph (a) of this section and in support of the Improper Payments Information Act to estimate improper payments using the PERM methodology for the Medicaid and SCHIP programs on an annual basis. The States are further required to submit payment error rates to CMS for the purpose of calculating a national level payment error rate.

This provision in the proposed rule would ensure the consistency of State estimates of improper payments through the monthly sample and review of Medicaid and SCHIP claims in which Federal funds were paid for services furnished in both the fee-for-service and managed care settings. The PERM methodology requires sampling from the Medicaid universe and SCHIP universe, reviewing sampled claims, and reporting results. Using specified formulas, the improper payment estimate for each program is based on the gross total of overpayments and underpayments (that is, the absolute value rather than the net value) and payments to ineligible. The estimate is also within ± 3 percent of the true population error rate with 95 percent confidence.

Section 431.958 Definitions and Use of Terms

In § 431.958, we propose the following definitions and use of terms for part 431, subpart Q:

Adjustments to claims means that adjustments to claims are not included in the universe from which the sampled claims/line items are drawn. However, all adjustments to a sampled claim that occur within 60 calendar days after the payment adjudication date would be included in the review of the sampled claim.

Improper payment means any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements; and includes any payment to an ineligible recipient, any payment for an ineligible

service, any duplicate payment, payments for services not received, and any payment that does not account for credit for applicable discounts.

Payment means any payment to a provider, insurer or managed care organization for a Medicaid or SCHIP recipient for which there is Medicaid or SCHIP Federal financial participation.

Payment error rate means an annual estimate of improper payments made under Medicaid and SCHIP equal to the sum of the overpayments (including payments to ineligible recipients) and underpayments, expressed as a percentage of total payments made over the sampling period.

Payment error rate change means the percentage point change in the payment error rate from one year to the next year.

PERM stands for Payment Error Rate Measurement.

Precision level means an estimate that is within ± 3 percentage points of the true population payment error rate with 95 percent confidence for the Medicaid program and for the SCHIP program, and within ± 4 percentage points of the true population payment error rate with 90 percent confidence for each fee-for-service component and managed care component in the Medicaid program and the SCHIP program. Sample sizes for each component should be sufficient to achieve the required precision level for Medicaid and SCHIP when the components are combined into a program estimate. If the State's Medicaid or SCHIP program consists of only one component, the precision level as defined for the Medicaid and SCHIP programs applies.

Sampling period means the sampling period is October 1 through September 30.

Sampling unit means the individually priced service line item drawn from the universe, whether paid or denied. On claims with multiple line items that are not individually priced, the claim is the sampling unit. Capitation payments or premium payments are considered line items for the purpose of sampling, reviewing, and calculating an error rate.

Total estimated improper payments means the estimate of the combined total amount of Federal and State improper payments as projected to the universe.

Universe—means the entirety of all paid and denied claims/line items submitted by providers, insurers, or managed care organizations that were received and processed for Medicaid or SCHIP payment during the sampling period. The Medicaid universe consists of all claims/line items, including capitated payments or premium payments, for which the State claimed

title XIX Federal funds or would have claimed title XIX Federal funds if the claim had not been denied. The SCHIP universe consists of all claims/line items, including capitated payments or premium payments, whether made under a Medicaid expansion or separate child health program, for which the State claimed title XXI Federal funds or would have claimed title XXI Federal funds if the claim had not been denied. Provider, insurer, or managed care organization claims that were adjudicated but for which no payment was made are included in the appropriate universe (Medicaid or SCHIP). Claims that cannot be processed and adjudicated for payment are not included in the universe.

Section 431.962 State Plan Requirements

In § 431.962, we propose that the State plan would implement the PERM program for estimating the payment error rate in both Medicaid and SCHIP annually; the State would submit those estimates to the Secretary by June 1 following the most recently completed annual error rate estimation for the purpose of CMS calculating and reporting a national payment error rate for these programs to OMB by November 15. This timeline is necessary for OMB to compile the information in the Department's Performance and Accountability Report to the Congress.

Section 431.966 Protection of Recipient Rights

In § 431.966, we propose that State collection and review of documentation for the purpose of conducting payment error rate measurement must be done in a manner that is consistent with the rights of recipients including those required under § 435.901 and § 435.902.

Section 431.970 Payment Error Rate

In § 431.970, we propose that States must submit to the Secretary payment error rates for both Medicaid and SCHIP annually. Payment error rates would be estimated based upon the documentation review of a random sample of paid and denied claims/line items drawn from the universe of claims from each program. The payment error rate estimate must meet the required precision level in each program.

The goal of PERM is to produce a State-level estimate of the Medicaid error rate and the SCHIP error rate that meets or exceeds required precision levels and that also can be aggregated to a national level error rate for each program. Within both the Medicaid and the SCHIP program, separate monthly samples should be drawn for fee-for-

service claims or line items and managed care or insurance premium payments, if applicable to the State. Separate estimates of a fee-for-service error rate and managed care error rate will be estimated from these samples for each program, as applicable to the State. The precision level at either the fee-for-service or managed care level can be lower than the precision requirements at the State's program level for Medicaid and for SCHIP. However, when the separate estimates for the State's fee-for-service and managed care samples are combined into an overall error rate at the State's program level, the estimate should meet or exceed the precision requirements specified for the program level estimate.

Section 431.974 Basic Elements of PERM

States would estimate improper Medicaid and SCHIP payments using the PERM methodology and report error rates to the Secretary annually. We would use the State level estimates to produce estimates of improper payments for both Medicaid and SCHIP at the national level. All States would use the State findings to address error causes that result in improper payments in their Medicaid and SCHIP programs in order to reduce the rate of improper payments in those programs.

Section 431.978 Sampling Procedures

1. Universe of Medicaid Claims

The Medicaid claims universe will consist of all Medicaid fee-for-service (FFS) adjudicated claims/line items paid to providers, insurers, and managed care organizations and that were denied for payment to providers, insurers, and managed care organizations in which the State claimed title XIX matching Federal funds. The universe includes all monthly managed care capitation payments made to health care organizations under a Medicaid managed care plan or a premium payment made to an insurer on behalf of a Medicaid beneficiary. Because we are reviewing only claims submitted by providers, insurers, and managed care organizations for which a decision to pay or deny was made by Medicaid or SCHIP, the universe would not include any non-claims-based payments or claims returned to providers because of submission errors. Examples of non-claims-based payments to providers are disproportionate share payments and aggregate cost settlement payments.

2. Universe of SCHIP Claims

The SCHIP claims universe consists of all fee-for-service SCHIP adjudicated claims/line items paid to providers and that were denied for payment for which the State claimed SCHIP enhanced Federal funding under title XXI, along with all capitation payments made to health care organizations, or premium payments to insurers on behalf of SCHIP recipients.

For fee-for-service SCHIP programs that are Medicaid Expansion programs, the SCHIP claims for which enhanced Federal funds were either paid or denied under title XXI must be separated from those Medicaid claims either paid or denied with title XIX Medicaid matching funds. These claims would be added to claims or payments from other fee-for-service SCHIP programs the State may offer, with the total constituting the universe for fee-for-service SCHIP.

If the State has both a separate fee-for-service SCHIP program and a Medicaid expansion that is fee-for-service, the claims from both would be pooled for sampling purposes.

3. Treatment of Medicaid and SCHIP Managed Care Claims

Medicaid capitated payments would consist of capitated premium payments for managed care enrollees paid to health care maintenance organizations (HMOs) or providers for which Federal funds were claimed. These payments would be considered as if they were "claims," similar to fee-for-service claims, for the purpose of forming the sampling universe for Medicaid.

SCHIP capitated payments and premium payments to insurers for both Medicaid expansions and separate child health programs are also considered as if they were "claims," similar to fee-for-service claims, for the purpose of forming the sampling universe for SCHIP.

We do not consider monthly management fees paid to primary care physicians under a primary care case management program as capitation payments. Those payments, however, should be considered as fee-for-service claims for the purpose of estimating improper payments.

4. Time Period for Sampling

The sample must be drawn from a universe of all claims paid in the annual period October 1 through September 30. The monthly sample must be drawn from paid and denied claims/line items made through the 12-month sampling period as estimated to result in approximately the same number of

claims to be reviewed each month. We anticipate each State will have an annual sample size ranging from 800–1200 claims for each program. The State-specific estimates of improper payments would be used to calculate the national estimate for the Federal fiscal year. States must submit a sampling plan to CMS for approval 30 days before the beginning of the sample period. CMS will respond to the States' sampling plan submittals in a timely manner. The State must receive approval for a plan before it can be implemented. If an approved plan is unchanged from a previous sampling period, the State is not required to resubmit the plan for approval. However, once the basic structure of the sample process is approved and implemented, all States are required at the beginning of each sample period to make the necessary updates and/or adjustments due to fluctuations in the universe as enrollment numbers change that result in the appropriate sample size. States are not required to submit these minor plan updates/adjustments to CMS for approval before implementation.

5. Sample Sizes

For the Medicaid and SCHIP program, the sample size would be drawn to obtain an estimate of the payment error rate that is within ± 3 percentage points of the true population payment error rate, with 95 percent confidence for each of the two programs. However, if the State has both a fee-for-service and a managed care component to its Medicaid or SCHIP programs, a sample stratified between the fee-for-service and managed care components must be drawn for each program. To contain costs, however, the required minimum precision levels for the samples at the component level are reduced. If both a fee-for-service and a managed care sample are drawn for Medicaid or for SCHIP, the fee-for-service estimate and the managed care estimate may, individually, satisfy a lower precision requirement. Specifically, if both a fee-for-service and a managed care sample are drawn for Medicaid or for SCHIP, the sample size of each component individually should be sufficient to achieve a precision level of ± 4 percentage points of the true error rate for the fee-for-service or managed care population, at a confidence level of 90 percent. The separate component level estimates will then be combined to produce a single program level estimate for Medicaid and for SCHIP. Regardless of the required minimum precision requirements at the component level, samples' sizes must be sufficient at the

fee-for-service and/or managed care component level when combined to meet Medicaid and SCHIP program level precision requirements. The State will report estimates for both the Medicaid and SCHIP program levels and the FFS and managed care component levels.

Section 431.982 Review Procedures for Fee-for-Service Claims

States sometimes make a correction or "adjustment" to a claim to correct an inaccuracy in the original claim payment. These adjustments could be made to correct the billing amount, coding, or other items. In reviewing claims, an adjustment to any claim that affects the payment amount would be reviewed if the adjustment occurred within 60 calendar days after the payment adjudication date. Adjustments to claims before to 60 days of the payment adjudication date would not be reviewed nor would claims adjustments be sampled as a separate sample unit.

In § 431.982, we propose that the review for FFS claims would differ slightly from those of capitated claims or premium payments. The following describes the review procedures for fee-for-service claims. The review would consist of processing validation, eligibility, and medical review.

1. Processing Validation

Each line item would be reviewed to validate that it was processed correctly, based on the information that is on the claim. At the minimum, review the claim to determine if it is:

- A duplicate item (claim);
- A non-covered service;
- A service covered by an HMO (that is, beneficiary is enrolled in a managed care organization that should have covered the service);
- Subject to third party liability payment;
- An invalid price;
- A logic edit (for example, incompatibility between gender and procedure); or
- Data entry (clerical) errors.

2. Eligibility Reviews

The eligibility review documents that the beneficiary was eligible for Medicaid or SCHIP at the time the service was received through case record review and field investigation. During the case record review, specific facts are collected about the circumstances of the beneficiary. The field investigation is required to verify the information. The determination of beneficiary eligibility is accomplished by applying the State's Medicaid or SCHIP eligibility policies in effect as of

the month the service was received (or the date of service in States that do not provide full month coverage). To determine if the beneficiary was eligible at the time of service, the reviewer would verify categorical (for example, aged, blind, disabled, minor child) and financial eligibility (for example, income, resources) through a desk review of the case record that documents eligibility at the time of service and would verify appropriate, outdated, or missing elements of eligibility through documentation, data matches such as the Income and Eligibility Verification System, and third party sources, for example, bank records, employer's wage verification, landlords. A face-to-face interview with the beneficiary is optional but must be conducted for any claim where eligibility at the date of service could not be verified through the desk review and field investigation.

The eligibility verification review would generally follow the procedures established by Medicaid Eligibility Quality Control (MEQC) [§ 431.812 (e)(1) through (e)(4)] except that States must not apply the administrative period. The administrative period is a timeframe under the MEQC program that provides a reasonable period of time for States to reflect changes in the beneficiary's circumstances without an error being cited. The administrative period is the sample month and month before the sample month. When an eligibility error occurs during this time because the beneficiary's circumstances changed (for example, income increased), no eligibility error exists (as long as the case would otherwise be eligible except for this error) because the agency did not have enough time to react to the change and correct the case. We propose to exclude the administrative period in the PERM regulation because it is resource-intensive to review eligibility for both months to determine if the error occurred during that time and that the change in circumstances is the sole reason for the error. We also believe that the intent of the PERM program is to focus on eligibility only at the time the service was received. Therefore, under the PERM rule, the month the service was received is the only month that States would review beneficiary eligibility and the administrative period would not apply.

Medicaid law at section 1902(a)(10)(A)(i)(I) of the Act requires States to make medical assistance available to individuals receiving aid or assistance under title XVI. Under section 1634 of the Act, the Social Security Administration (SSA) may

enter into an agreement with any State under which the SSA will determine the Medicaid eligibility of Supplemental Security Income (SSI) cash recipient cases. In a State with such an agreement with the SSA, the State must verify Medicaid eligibility by confirming, through the State Data Exchange, that the beneficiary was an SSI recipient for the month the Medicaid service was provided.

Eligibility reviews would determine that the beneficiary was eligible for Medicaid in the month the sampled service was provided (or on the date of service in States that do not provide full-month coverage). Eligibility reviews would also be conducted for the SCHIP sample in the same manner the reviews are conducted for the Medicaid sample. Individual cases found with an error that could affect eligibility should be reported to the appropriate unit for action.

3. Medical Review

We propose that medical record requests to providers via mail are sufficient. At the minimum, the medical review would include review of—

- The guidelines and policy related to the claim;
- Medical record documentation;
- Medical necessity; and
- Coding accuracy.

Section 431.986 Review for Capitated Payments and Premium Payments

1. Data Processing

Each capitation payment and premium payment would be reviewed to validate that it was processed correctly. The review would include the following:

- Data entry error.
- Invalid pricing.
- Duplicate item (claim).

Moreover, if the plan includes a capitation payment or premium that varies depending upon the characteristics of the recipient (risk-adjusted payments, for example) the review must determine that the precise capitated payment or premium payment was accurate for that recipient. In some cases, this may require some clinical expertise.

2. Eligibility Review

In § 431.986, we propose that the eligibility review of recipients on whose behalf a capitated payment or premium was paid is the same as that for recipients for fee-for-service claims. That is, the State would verify that the beneficiary was eligible for Medicaid or SCHIP, as appropriate, in the month the service was received (or the date of

service in States that do not provide full month coverage) by verifying that the beneficiary met the categorical and financial eligibility requirements according to the State's eligibility policies in effect in the month in which the service was received. In addition, however, the review must determine if the recipient was eligible and actually enrolled for the particular health care plan for which the premium was made.

3. Medical Review

Unlike fee-for-service claims, there is no explicit medical review of a particular service.

Reporting and Recordkeeping Requirements and Recoveries

Section 483.990 Reporting Requirements and Recordkeeping

In § 483.990, we propose that States must report, annually, improper payment estimates to the Secretary by June 1, 9 months after the previous October 1 through September 30 sampling period. States must also submit an Annual PERM Report to CMS by June 1 following the previously completed sampling period. The report must list the errors which the State identified in its review (and identify which amounts were overpayments, underpayments, and payments for ineligible individuals/services), explain the causes of the errors and explain the actions it will take to address those errors and to reduce the level of improper payments.

We also propose that, for purposes of this regulation, States retain documentation to support the testing and statistical calculation of the Medicaid and SCHIP PERM error rate estimates, particularly statistical, fiscal, and other records necessary for reporting and accountability as required by the Secretary. For those records that pertain to the PERM program, we propose that States maintain and permit ready access and use of those records, including but not limited to the eligibility case records, review materials, working papers, reports, sampling plans, and statistical data and all other documentation needed to support the State's Medicaid and SCHIP error rates. These records may be used for Federal re-review or audits by the Department of Health and Human Services (DHHS), HHS Office of the Inspector General and the Government Accountability Office. Similarly, for purposes of this regulation, we propose that States retain these records for 3 years from the date of submission of a final expenditure report or beyond 3

years if audit findings have not been resolved.

Section 431.1002 Recoveries

OMB guidance for implementing the Improper Payments Information Act requires us to include in our report to the Congress a discussion regarding recovery of misspent funds. We propose to include a provision that States would return to us within 60 days the Federal share identified as overpayments actually identified in the sampled claims reviewed for data processing and medical necessity in accordance with 42 CFR part 433, subpart F. Payments based on erroneous eligibility determinations are exempt from this provision because these payments are addressed under section 1903(u) of Act.

Subchapter D—State Children's Health Insurance Programs (SCHIP)

Part 457—Allotments and Grants to States

Subpart G—Strategic Planning, Reporting, and Evaluation

Section 457.720 State Plan Requirements: State Assurance Regarding Data Collection, Records, and Reports

We propose to revise § 457.720 to make a conforming change to cross-reference § 431.950 through § 431.1002 in order to make it easy for States to find the rules governing the PERM program.

III. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

We are soliciting public comment on each of these issues for the following sections of this document that contain information collection requirements:

Section 431.962 State Plan Requirements

In summary, § 431.962 requires State plans to provide for the submission of payment error rate estimates for both Medicaid and SCHIP to the Secretary.

The burden associated with this requirement would be 51 (the number of States and the District of Columbia that need to amend their State Plan to include this requirement) \times 1 (the hours it would take for them to amend the plan), or 51 hours annually.

The information collection for amending State Plans is currently approved under OMB number 0938–0193.

This assumes that all States would conduct PERM as required by the regulation. Therefore, the State plan would be amended in all 50 States plus the District of Columbia. Amending the State plan requires 1 hour in order for the State to sign and submit an additional form with their plan that outlines what the State is required to do under the PERM regulation; the form does not require preparation by State.

Section 431.970 Payment Error Rate

Section 431.970(a) requires States to submit payment error rates for both Medicaid and SCHIP annually.

The burden associated with this requirement would be the time it would take each State to gather and calculate the data using the PERM methodology, for both Medicaid and SCHIP, and then report their payment error rates findings to the Secretary.

It is estimated that it would take 24,000 hours per State to comply with this requirement, or a total of 1,224,000 hours (# of States \times hours/State). This assumes that during any given Federal fiscal year beginning with FY 2006, a maximum of 50 States plus the District of Columbia will be conducting PERM as required by this proposed rule. This further assumes that each of the 51 participating States will be conducting PERM on a sample of approximately 2,000 paid/denied claims/line items. Each sampled claim reviewed under PERM generally requires 12 hours as follows: 10 hours for eligibility verification case review, 1 hour for medical records review and processing validation, and 1 hour of administrative/professional time. Therefore, 2,000 claims (\times) 12 hours per claim equals 24,000 hours per State (\times) 51 States per year equals 1,224,000 total hours per year.

Section 431.978 Sampling Procedure

Section 431.978 requires States to submit initial sampling plans for CMS

for approval 30 days before implementation. The burden associated with this requirement is the time it takes each State to develop a sampling plan. Based on the cost efficiency study from the second year of the PAM research and demonstration project, we estimate that it will take approximately 84 hours to develop a sampling plan for sampling a total average of 1,000 to 2,000 claims. The total burden is 84 hours per program = 168 per State (\times) 51 States = 8,568 hours. If a plan is unchanged from a previous period, the State is not required to resubmit the plan for approval. Once States have established an approved sampling plan, they may need to make minor adjustments to maintain the proper sample size but do not need to obtain CMS approval for these minor changes.

Section 431.990 Reporting Requirements and Recordkeeping

Section 431.990(a) requires States to annually report the total estimated improper payments and payment error rates to the Secretary.

The burden associated with this requirement is the time it takes each State to annually gather the total estimated improper payments and payment error rates and report this to the Secretary by June 1. The burden associated with this requirement is included in the burden under the payment error rate requirements in § 431.970.

Section 431.990(b) requires States to submit an Annual PERM Report to CMS.

The burden associated with this is the time it will take for the States to prepare the report that addresses actions to be taken to address error causes and that are designed to reduce payment error and submit this report to CMS. It is estimated that it will take a State 40 hours to prepare and submit the report to CMS. The burden associated with this requirement would be 51 (the number of States and the District of Columbia) \times 40 hours (the hours it would take for each State to prepare the report) or 2040 hours. The cost associated with preparing the Annual PERM Report for each State is \$1040. That amount is based on a State employee hourly wage figure computed at 80 percent of a GS 12/Step 1 salary plus 10 percent retirement/insurance as follows: \$60,638 (GS 12) + \$6063 (10 percent retirement/insurance) \times 80 percent = \$53,360/2080 hours per year = \$26 per hour (rounded). \$26 per hour \times 40 hours = \$1040 51 States \times \$1040 = \$53,040 total annual State cost (applicable Federal match is available).

For purposes of maintenance of records, we propose that States retain

documentation to support the testing and statistical calculation of the Medicaid and SCHIP error rate estimates, particularly statistical, fiscal, and other records that pertain to the PERM program as are necessary for reporting and accountability as required by the Secretary. For those records that pertain to the PERM program, we propose that States maintain and permit ready access and use of all official records, including but not limited to the eligibility case records, review materials, working papers, reports, sampling plans, and statistical data and all other documentation needed to support the State's Medicaid and SCHIP error rates. These records may be used for Federal re-review or audits by the DHHS, HHS Office of the Inspector General and the Government Accountability Office. Since these regulatory requirements are similar to longstanding record retention requirements in Medicaid (refer to 44 FR 17931, March 23, 1979, as amended at 51 FR 7210, February 28, 1986) and the records and working papers that States will use already exist to a large extent, *e.g.*, Medicaid and SCHIP eligibility case records used for eligibility reviews and working papers already available through the MEQC program, and that States' systems of recordkeeping have become technologically sophisticated through computer programming, we estimate that this recordkeeping requirement under the PERM program does not present any additional burden on States. Also, this requirement is similar to current SCHIP regulations at § 457.226 that require States to maintain an accounting system and supporting fiscal records to ensure that claims for Federal funds are in accord with applicable Federal requirements and to retain records for 3 years from the date of submission of a final expenditure report or beyond 3 years if audit findings have not been resolved. Since States are already required to maintain records under SCHIP, we estimate that this requirement for the PERM program does not present an additional burden to States.

If you comment on these information collection and recordkeeping requirements, please mail copies directly to the following:

Centers for Medicare & Medicaid Services, Office of Strategic Operations and Regulatory Affairs, Regulations Development and Issuances Group, Attn: Melissa Musotto, Room C5-14-03, 7500 Security Boulevard, Baltimore, MD 21244-1850; and

Office of Information and Regulatory Affairs, Office of Management and

Budget, Room 10235, New Executive Office Building, Washington, DC 20503, Attn: Christopher Martin, CMS Desk Officer.

Comments submitted to OMB may also be e-mailed to the following address: e-mail:

Christopher.Martin@omb.eop.gov; or faxed to OMB at (202) 395-6974.

IV. Response to Comments

Because of the large number of items of correspondence we normally receive on **Federal Register** documents published for comment, 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 major comments in the preamble to that document.

V. Regulatory Impact Statement

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

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).

Based upon the cost efficiency study from States participating in the second year of the PAM research and demonstration project from which the PERM methodology was developed and pilot tested, we estimate that the average cost, based on an average of 1,000 claims, would be as follows: \$570 per eligibility review, \$300 per claims review (data processing and medical review), and \$155 standard administrative cost. Based on these figures, we estimate that the total annual State and Federal costs to conduct

PERM would range from \$1 to \$2 million. Therefore, we have determined that the proposed rule would not exceed the annual \$100 million threshold impact criterion. Therefore, an impact analysis is not required under E.O. 12866.

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 government agencies. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of \$6 million to \$29 million in any 1 year. Individuals and States are not included in the definition of a small entity. The proposed rule would require State governments to estimate payment error in Medicaid and SCHIP using the PERM methodology. State governments are not defined as small entities in the RFA. Therefore, an impact analysis is not required under the RFA.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 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.

The proposed rule applies to State governments and does not apply to small rural hospitals. Therefore, an impact analysis is not required under section 1102(b) of the Social Security Act.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule that may result in expenditure in any 1 year by State, local, or tribal governments, in the aggregate, or by the private sector, of \$110 million.

As discussed previously, based upon preliminary cost estimates from State participation in the second year of the PAM research and demonstration project from which the PERM methodology was developed and pilot tested, we have estimated that the total computable (State and Federal) cost will range from \$1 to \$2 million to operate PERM annually. Therefore, we have determined that the proposed rule would not result in expenditures by State, local, or tribal governments, in the aggregate, or by the private sector that exceed the annual \$110 million threshold impact criterion. Therefore, an impact analysis is not required under

section 202 of the Unfunded Mandates Reform Act of 1995.

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.

The proposed rule would require States to produce payment error rate estimates using the PERM methodology. The two major cost factors for each State implementing the PERM methodology are the medical review of the sampled claims and the eligibility verification of the beneficiaries associated with the sampled claims. States must conduct medical review of the sampled claims with participation from nurse level staff. States must also conduct field visits to obtain documentation and interview beneficiaries, if necessary, in order to verify eligibility. The labor costs and travel costs associated with these staff would vary by State. These costs are also driven by the size of the claims sample that would vary by State, which we estimate to be 800 to 1,200 per program. Other less significant expenses incurred by States include both the cost of program administration and the cost of professional staff to draw the sample, estimate the payment error rate, and produce reports. We estimate the total computable (State and Federal) cost, based on an average of 1,000 claims, will be an average of \$870,000 to conduct the reviews and \$155,000 in administrative expenses for a total range of \$1 to \$2 million.

Preliminary cost estimates were based on a cost analysis of States' participating in the research and demonstration project from which the PERM methodology was developed and pilot tested. From this analysis, we estimate that States should be able to conduct PERM annually for between \$1 to \$2 million, with most States at the lower end of that range, which includes the applicable Medicaid and SCHIP Federal match.

This proposed rule is intended to produce savings for the States. These savings would result from actions taken by the States to address error causes identified in the claims processing system and other program areas, as appropriate. These savings cannot be estimated until after each State has conducted PERM for successive years in order that reductions in payment error rates can be reported and potential savings to the State can be estimated.

B. Anticipated Effects

The State may request that medical providers supply medical records or other similar documentation that verify the provision of medical services to a beneficiary, for a paid or denied Medicaid or SCHIP claim that was sampled and reviewed for payment error as part of PERM. This action would not have a significant cost impact on medical providers.

C. Alternatives Considered

The PERM methodology has been designed to promote savings for the Medicaid and SCHIP programs by reducing payment error. We would like to solicit comments on how to implement the PERM methodology at the State level in a manner that ensures independence and minimizes conflicts of interest.

The PERM methodology has been developed and pilot tested with extensive collaboration from participating States during a 3-year research and demonstration project. Alternatives were considered and pilot tested during the research and demonstration project period. We considered having CMS or a contractor use the PERM methodology to construct national improper payment estimates annually for Medicaid and SCHIP. We rejected this approach because no single Federal entity or contractor is expert in the unique eligibility, service, coverage, and reimbursement policies of every State. Also, in State-administered programs like Medicaid and SCHIP, the State itself must identify error causes, based on PERM reviews, and take actions to reduce the level of improper payments.

We considered a process for estimating improper payments in both Medicaid and SCHIP through a rotation process whereby each State would participate in a sample and review of claims for each program once every 3 years. This was rejected because of concern that excluding some States from the sampling frame in a given year may bias the national estimate.

Randomly sampling States each year to produce a national estimate was also considered. It was rejected because it would not provide an estimate for each State on a systematic basis. Consequently, CMS would not be able to routinely monitor individual State progress and provide technical assistance to achieve error reduction.

The draft final specifications of the methodology have been developed in collaboration with the participating States. The methodology has also been designed to minimize costs to the States

and to be in compliance with the requirements of the Improper Payments Information Act of 2002 and the related guidance from the Office of Management and Budget.

In accordance with E.O. 12866, this proposed rule was reviewed by the Office of Management and Budget.

List of Subjects

42 CFR Part 431

Grant programs—health, Health facilities, Medicaid, Privacy, Reporting and recordkeeping requirements.

42 CFR Part 457

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

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

PART 431—STATE ORGANIZATION AND GENERAL ADMINISTRATION

1. The authority citation for part 431 continues to read as follows:

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

2. Part 431 is amended by adding new subpart Q to read as set forth below:

Subpart Q—Requirements for Estimating Improper Payments in Medicaid and SCHIP

Sec.

431.950 Purpose.

Review and Sample Procedures for Estimating Improper Payments in Medicaid and SCHIP

431.954 Basis and scope.

431.958 Definitions.

431.962 State plan requirements.

431.966 Protection of recipient rights.

431.970 Payment error rate.

431.974 Basic elements of PERM.

431.978 Sampling procedures.

431.982 Review procedures.

431.986 Review for capitated payments and premium payments.

Reporting and Recordkeeping Requirements and Recoveries

431.990 Reporting requirements and recordkeeping.

431.1002 Recoveries.

Subpart Q—Requirements for Estimating Improper Payments in Medicaid and SCHIP

§ 431.950 Purpose.

This subpart requires States to annually estimate total improper payments and produce payment error rates in Medicaid and SCHIP using the Payment Error Rate Measurement (PERM) methodology and to provide these estimates to the Secretary by June 1 for the purpose of HHS developing a

national estimate of improper payments in those programs. In conducting medical records reviews and eligibility reviews, States must adhere to the requirements of protection of recipients' rights including those in § 435.901 and § 435.902 of this chapter.

Review and Sample Procedures for Estimating Improper Payments in Medicaid and SCHIP

§ 431.954 Basis and scope.

(a) *Basis.* The statutory bases for this subpart are sections 1102, 1902(a)(6), and 2107(b)(1) of the Act, which contain the Secretary's general rulemaking authority and obligate States to provide information, as the Secretary may require, to monitor program performance. In addition, this rule supports the Improper Payments Information Act of 2002, which requires Federal agencies to annually review and identify those programs and activities that may be susceptible to significant erroneous payments, estimate the amount of improper payments, and report those estimates to the Congress and, if necessary, submit a report on actions the agency is taking to reduce erroneous payments.

(b) *Scope.* This subpart requires States under the statutory provisions in paragraph (a) of this section to estimate improper payments using the PERM methodology annually in the Medicaid and SCHIP programs. The States are further required to submit payment error rates annually to the Secretary for the purpose of calculating a national level payment error rate.

§ 431.958 Definitions and use of terms.

Adjustments to claims means that adjustments to claims are not included in the universe from which sampled claims/line items are drawn. However, all adjustments to a sampled claim that occur within 60 calendar days after the payment adjudication date would be included in the review of the sampled claim.

Improper payment means any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements; and includes any payment to an ineligible recipient, any payment for an ineligible service, any duplicate payment, any payment for services not received, and any payment that does not account for credits or applicable discounts.

Payment means any payment to a provider, insurer, or managed care organization for a Medicaid or SCHIP

recipient for which there is Medicaid or SCHIP Federal financial participation.

Payment error rate means an annual estimate of improper payments made under Medicaid and SCHIP equal to the sum of the overpayments (including payments to ineligible recipients) and underpayments, that is, the absolute value, expressed as a percentage of total payments made over the sampling period.

Payment error rate change means the percentage point change in the payment error rate from 1 year to the next year.

PERM stands for Payment Error Rate Measurement.

Precision level means an estimate that is within ± 3 percentage points of the true population payment error rate with 95 percent confidence for the Medicaid program and for the SCHIP program, and within ± 4 percentage points of the true population payment error rate with 90 percent confidence for each fee-for-service component and managed care component in the Medicaid program and the SCHIP program. Sample sizes for each component should be sufficient to achieve the required precision level for Medicaid and SCHIP when the components are combined into a program estimate. If the State's Medicaid or SCHIP program consists of only one component, the precision level as defined for the Medicaid and SCHIP programs applies.

Sampling period means the sampling period is October 1 through September 30.

Sampling unit means the individually priced service line item drawn from the universe, whether paid or denied. On claims with multiple line items that are not individually priced, the claim is the sampling unit. Capitation payments or premium payments are considered line items for the purpose of sampling, reviewing, and calculating an error rate.

Total estimated improper payments means the estimate of the combined total amount of Federal and State improper payments as projected to the universe.

Universe means the entirety of all paid and denied claims/line items submitted by providers, insurers, and managed care organizations that were received and processed for Medicaid or SCHIP payment during the sampling period. The Medicaid universe consists of all claims/line items, including capitated payments or premium payments, for which the State claimed title XIX Federal funds or would have claimed title XIX Federal funds if the claim had not been denied. The SCHIP universe consists of all claims/line items, including capitated payments or premium payments, whether made

under a Medicaid expansion or separate child health program for which the State claimed title XXI Federal funds or would have claimed title XXI Federal funds if the claim had not been denied. Provider, insurer, and managed care organization claims that were adjudicated but for which no payment was made are included in the appropriate universe (Medicaid or SCHIP). Claims that cannot be processed and adjudicated for payment are not included in the universe. Within Medicaid and within SCHIP, fee-for-service payments and managed care payments will be considered separately for the purpose of sampling.

§ 431.962 State plan requirements.

The State plan must—

(a) Provide for estimating the payment error rate in both Medicaid and SCHIP and the respective fee-for-service and managed care components, as applicable; and

(b) Submit payment error rate estimates in both Medicaid and SCHIP to the Secretary by June 1 annually for the purpose of HHS reporting a national payment error rate for these programs.

§ 431.966 Protection of recipient rights.

State collection and review of documentation for the purpose of conducting payment error rate measurement must be done in a manner that is consistent with the rights of recipients including those required under § 435.901 and § 435.902.

§ 431.970 Payment error rate.

(a) States must submit to the Secretary payment error rates for both Medicaid and SCHIP annually.

(b) Payment error rates are estimated based upon the documentation review of a random monthly sample of paid and denied claims/line items drawn from the universe of claims from each program.

(c) The payment error rate estimate must meet the required precision level, as defined in § 431.958, in each program and component.

§ 431.974 Basic elements of PERM.

(a) States must estimate improper Medicaid and SCHIP payments through a review of randomly selected claims.

(b) States must take actions in their Medicaid and SCHIP programs to address causes of errors identified through the claims reviews.

(c) States must submit an Annual PERM Report to CMS by June 1 following the sample year. The Annual PERM Report must detail the causes of error (identified through the PERM claims reviews) that result in improper

payments and specify actions to be taken to address the error causes and to reduce the level of improper payments.

§ 431.978 Sampling procedures.

(a) States must draw a statistically valid random sample from the Medicaid universe and the SCHIP universe, as defined in § 431.958, that is of sufficient size to ensure that it meets the required precision level for each program and component as defined in 431.958.

(b) The sample must be drawn monthly throughout the annual sampling period.

(c) For a State with both a fee-for-service and managed care component to its Medicaid and/or SCHIP program, a sample stratified between these components must be drawn for each program. Component sample sizes must be sufficient, when combined, to meet the Medicaid and SCHIP program level precision requirements.

(d) States must submit a sampling plan to CMS for approval 30 days before the beginning of the sample period and must receive approval of the plan before implementation. If a plan is unchanged from a previous period, the State is not required to resubmit the plan for approval.

(e) States must make minor updates and adjustments to the plan due to fluctuations in the universe as enrollment numbers change that results in appropriate sample sizes. States are not required to obtain CMS approval for these minor changes.

§ 431.982 Review procedures.

(a) *Fee-for-service line items.* The review of fee-for-service line items, including adjustments to claims that occur within 60 calendar days after the payment adjudication date, must consist of three parts:

(1) Processing Validation. At minimum, review the claim to determine if it is—

- (i) A duplicate item (claim);
- (ii) A non-covered service;
- (iii) A service covered by an HMO (that is, the beneficiary is enrolled in a managed care organization that should have covered the service);
- (iv) Subject to third party liability payment;
- (v) An invalid price;
- (vi) A logic edit (for example, incompatibility between gender and procedure); or
- (vii) A data entry (clerical) error.

(2) *Eligibility reviews.* The eligibility reviews for States are as follows:

(i) In a State that confers Medicaid or SCHIP eligibility on a month-to-month basis, the review must verify that the beneficiary was eligible for the

Medicaid or SCHIP program during the month the service was received by applying the State's policies and procedures in effect during that month.

(ii) In a State with day-specific Medicaid or SCHIP eligibility, the review must verify that the beneficiary was eligible for the Medicaid or SCHIP program on the date the service was received by applying the State's policies and procedures in effect on that date.

(iii) The eligibility verification review must follow the procedures established by Medicaid Eligibility Quality Control, as set forth in § 431.812(e)(1) through (e)(4), except that States must not apply the administrative period. In-person interviews are optional unless verification of eligibility cannot be made based on the case record review and appropriate documentation or collateral contacts.

(iv) In States with agreements with the Social Security Administration under section 1634 of the Act, the State must verify Medicaid eligibility by confirming, through the State Data Exchange, that the beneficiary was a Supplemental Security Income (SSI) cash recipient for the month or the date the Medicaid service was received.

(v) States must take appropriate action on individual error cases that could affect eligibility.

(3) *Medical review.* States may request medical records by mail. The medical review must, at a minimum, include review of—

- (i) The guidelines and policy related to the claim;
 - (ii) Medical record documentation;
 - (iii) Medical necessity; and
 - (iv) Coding accuracy.
- (b) [Reserved]

§ 431.986 Review for capitated payments and premium payments.

(a) The eligibility review of recipients on whose behalf a capitated payment or premium was paid is the same as that for recipients for fee-for-service claims.

(b) The review must verify that the recipient was eligible for and actually enrolled in the particular health care plan for which the premium or capitation payment was made. If the plan includes a capitation payment or premium that varies depending upon the characteristics of the recipient, the review must verify that the precise capitated payment or premium payment was accurate for that recipient.

(c) *Processing validation.* Each line item would be reviewed to validate that it was processed correctly, based on the information that is on the claim. At a minimum, the claim is reviewed to determine if it is—

- (1) A duplicate item (claim);

(2) A non-covered service;

(3) A service covered by an HMO (that is, the beneficiary is enrolled in a managed care organization that should have covered the service);

(4) Subject to third party liability payment;

(5) An invalid price;

(6) A logic edit (for example, incompatibility between gender and procedure); or

(7) A data entry (clerical) error.

(d) Medical records review is not required as part of the review of capitated payments.

(e) The claims review includes adjustments to claims that occur within 60 calendar days after the payment adjudication date.

Reporting and Recordkeeping Requirements and Recoveries

§ 431.990 Reporting requirements and recordkeeping.

(a) States must annually report total estimated improper payments and payment error rates to the Secretary by June 1 following the close of the sampling period.

(b) States must submit an Annual PERM Report to CMS by June 1 following the close of the sample period. The report must list the errors which the State identified in its review (and identify which amounts were overpayments, underpayments, and payments for ineligible individuals/services), explain the causes of the errors and explain the actions it will take to address those errors and to reduce the level of improper payments.

(c) States must retain documentation to support the testing and statistical calculation of the Medicaid and SCHIP error rate estimates, particularly statistical, fiscal, and other records necessary for reporting and accountability as required by the Secretary.

(d) States must maintain and permit ready access and use of all official records used for purposes of the PERM Report, including but not limited to the eligibility case records, review materials, working papers, reports, sampling plans, and statistical data and all other documentation needed to support the State's Medicaid and SCHIP error rates. These records may be used for Federal re-review or audits by the Department of Health and Human Services, HHS Office of the Inspector General and the Government Accountability Office.

(e) States must retain these records for 3 years from the date of submission of a final expenditure report or beyond 3 years if audit findings have not been resolved.

§ 431.1002 Recoveries.

States must return to CMS the Federal share of overpayments identified in the sampled claims reviewed for data processing and medical necessity within 60 days in accordance with section 1903(d)(2) of the Act and related regulations at part 433, subpart F of this chapter. Payments based on erroneous eligibility determinations are exempt from this provision because they are addressed under section 1903(u) of the Act and related regulations at part 431, subpart P of this chapter.

SUBCHAPTER D—STATE CHILDREN'S HEALTH INSURANCE PROGRAM**PART 457—ALLOTMENTS AND GRANTS TO STATES****Subpart G—Strategic Planning, Reporting, and Evaluation**

3. The authority citation for part 457 continues to read as follows:

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

2. Section 457.720 is revised to read as follows:

§ 457.720 State plan requirement: State assurance regarding data collection, records, and report.

A State plan must include an assurance that the State collects data, maintains records, and furnishes reports to the Secretary, at the times and in the standardized format the Secretary may require to enable the Secretary to monitor State program administration and compliance and to evaluate and compare the effectiveness of State plans under title XXI. This includes collection of data and reporting as required under § 431.950 through § 431.1002 of this chapter.

(Catalog of Federal Domestic Assistance Program No. 93.767, State Children's Insurance Program)

Dated: January 8, 2004.

Dennis G. Smith,

Acting Administrator, Centers for Medicare & Medicaid Services.

Approved: May 20, 2004.

Tommy G. Thompson,

Secretary.

[FR Doc. 04-19603 Filed 8-26-04; 8:45 am]

BILLING CODE 4120-01-P

FEDERAL COMMUNICATIONS COMMISSION**47 CFR Parts 0, 2 and 101**

[FCC 04-78; ET Docket No. 95-183; RM-8553; PP Docket No. 93-253]

37.0-38.6 GHz and 38.6-40.0 GHz Bands—Competitive Bidding

AGENCY: Federal Communications Commission.

ACTION: Proposed rule.

SUMMARY: In this document, the Commission proposes to amend the rules for fixed, point-to-point microwave service in the 38.6-40.0 GHz ("39 GHz") band, and to adopt a conforming set of new rules for the virtually unused 37.0-38.6 GHz ("37 GHz") band in order to allow for the expansion of 39 GHz type service. In this Third Notice of Proposed Rule Making, (Third NPRM), we propose service rules for the 37 GHz and also for the 42.0-42.5 GHz ("42 GHz") ("37/42 GHz") bands that would substantially conform to the rules adopted for the 39 GHz band in the *Report and Order* and *Second Notice of Proposed Rule Making* and the *Second Report and Order* in this proceeding. Our goal is to establish a flexible regulatory and licensing framework that would promote seamless deployment of a host of services and technologies in the 37 GHz and 42 GHz bands. We seek to enhance opportunities for deployment of broadband wireless services, foster effective competition, promote innovation and further our efforts for consistent rule application regarding broadband wireless services.

DATES: Comments are due on or before October 26, 2004, and reply comments are due to be filed by November 26, 2004. Written comments on the Paperwork Reduction Act proposed information collection requirements must be submitted by the public, Office of Management and Budget (OMB), and other interested parties on or before October 26, 2004.

ADDRESSES: In addition to filing comments with the Secretary, a copy of any comments on the Paperwork Reduction Act information collection requirements contained herein should be submitted to Judith B. Herman, Federal Communications Commission, Room 1-C804, 445 12th Street, SW., Washington, DC 20554, or via the Internet to Judith-B.Herman@fcc.gov, and to Kristy L. LaLonde, OMB Desk Officer, Room 10234 NEOB, 725 17th Street, NW., Washington, DC 20503, via the Internet to Kristy_L.LaLonde@omb.eop.gov, or via fax at (202) 395-5167.

LaLonde@omb.eop.gov, or via fax at (202) 395-5167.

FOR FURTHER INFORMATION CONTACT:

Charles Oliver (legal) or Michael Pollak (engineering), Wireless Telecommunications Bureau, (202) 418-2487. For additional information concerning the Paperwork Reduction Act information collection requirements contained in this document, contact Judith B. Herman at (202) 418-0214, or via the Internet at Judith-B.Herman@fcc.gov.

SUPPLEMENTARY INFORMATION: This is a summary of the Commission's Third NPRM, released on May 5, 2004, (FCC 04-78). The full text of the Third NPRM is available for inspection and copying during normal business hours in the FCC Reference Center, Room CY-A257, 445 12th St., SW., Washington DC 20554. The complete text may also be purchased from the Commission's duplicating contractor, Best Copy and Printing Inc., (BCPI), Portals II, 445 12th St., SW., Room CY-B402, Washington DC. Additionally, the complete item is available on the Commission's Web site at <http://www.fcc.gov/wtb>.

I. Summary of Notice of Proposed Rulemaking

1. In the Notice of Proposed Rule Making and Order that initiated the above-captioned proceeding in 1995, we proposed to amend the rules for fixed, point-to-point microwave service in the 38.6-40.0 GHz ("39 GHz") band, and to adopt a conforming set of new rules for the virtually unused 37.0-38.6 GHz ("37 GHz") band in order to allow for the expansion of 39 GHz-type service. In this Third NPRM, we propose service rules for the 37 GHz and also for the 42.0-42.5 GHz ("42 GHz") ("37/42 GHz") bands that would substantially conform to the rules adopted for the 39 GHz band in the *Report and Order* and *Second Notice of Proposed Rule Making* and the *Second Report and Order* in this proceeding. We recognize, however, that conditions have changed considerably over the past few years, and we are willing to consider alternatives if commenters demonstrate that a different regulatory framework would be more appropriate for the 37/42 GHz bands. Our goal is to establish a flexible regulatory and licensing framework that would promote seamless deployment of a host of services and technologies in the 37 GHz and 42 GHz bands. We seek to enhance opportunities for deployment of broadband wireless services, foster effective competition, promote innovation and further our efforts for consistent rule application regarding broadband wireless services.