§ 401.601 Basis and scope.

* * * * *

(d) * * *

(2) * * *

(ii) Adjustments in Railroad Retirement or Social Security benefits to recover Medicare overpayments to individuals are covered in §§ 405.350—405.358 of this chapter.

* * * * *

3. Section 401.607 is amended by revising paragraph (d)(2) to read as follows:

§ 401.607 Claims collection.

* * * * *

(d) * * *

(2) Under regulations at § 405.350—405.358 of this chapter, HCFA may initiate adjustments in program payments to which an individual is entitled under title II of the Act (Federal Old Age, Survivors, and Disability Insurance Benefits) or under the Railroad Retirement Act of 1974 (45 U.S.C. 231) to recover Medicare overpayments.

B. Part 405 is amended as set forth below:

PART 405—FEDERAL HEALTH INSURANCE FOR THE AGED AND DISABLED

1. The authority citation for part 405 subpart C continues to read as follows:

Authority: Secs. 1102, 1862, and 1871 of the Social Security Act (42 U.S.C. 1302, 1395y, and 1895hh).

2. Section 405.350 is amended by revising the introductory paragraph to read as follows:

§ 405.350 Individual's liability for payments made to providers and other persons for items and services furnished the individual.

Any payment made under title XVIII of the Act to any provider of services or other person with respect to any item or service furnished an individual shall be regarded as a payment to the individual, and adjustment shall be made pursuant to §§ 405.352 through 405.358 where:

* * * * *

3. Section 405.356 is revised to read as follows:

§ 405.356 Principles applied in waiver of adjustment or recovery.

The principles applied in determining waiver of adjustment or recovery (§ 405.355) are the applicable principles of § 405.358 and 20 CFR 404.507–404.509, 404.510a, and 404.512.

4. New § 405.357 is added to subpart C to read as follows:

§ 405.357 Notice of right to waiver consideration.

Whenever an initial determination is made that more than the correct amount of payment has been made, notice of the provisions of section 1870(c) of the Act regarding waiver of adjustment or recovery shall be sent to the overpaid individual and to any other individual against whom adjustment or recovery of the overpayment is to be effected (see § 405.358).

5. New § 405.358 is added to subpart C to read as follows:

§ 405.358 When waiver of adjustment or recovery may be applied.

Section 1870(c) of the Act provides that there shall be no adjustment or recovery in any case where an incorrect payment under title XVIII (hospital and supplementary medical insurance benefits) has been made (including a payment under section 1814(e) of the Act with respect to an individual:

(a) Who is without fault, and

(b) Adjustment or recovery would either:

(1) Defeat the purposes of title II or title XVIII of the Act, or

(2) Be against equity and good conscience.

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

Dated: July 1, 1996.

Bruce C. Vladeck,

Administrator, Health Care Financing Administration.

[FR Doc. 96–23957 Filed 9–18–96; 8:45 am]

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42 CFR Part 421

[BPO–105–F]

RIN 0938–AF85

Medicare Program; Part B Advance Payments to Suppliers Furnishing Items or Services Under Medicare Part B

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Final rule.

SUMMARY: This rule establishes requirements and procedures for advance payments to suppliers of Medicare Part B services. An advance payment will be made only if the carrier is unable to process a claim timely; the supplier requests advance payment; we determine that payment of interest is insufficient to compensate the supplier for loss of the use of the funds; and, we expressly approve the advance payment in writing.

These rules are necessary to address deficiencies noted by the General Accounting Office in its report analyzing current procedures for making advance payments. The intent of this rule is to ensure more efficient and effective administration of this aspect of the Medicare program.

EFFECTIVE DATE: This rule is effective October 21, 1996.

FOR FURTHER INFORMATION CONTACT: Robert Shaw, (410) 786–3312.

SUPPLEMENTARY INFORMATION:

I. Background

A. General

The Medicare Supplementary Medical Insurance (Part B) program is a voluntary program that pays all or part of the costs for physicians' services; outpatient hospital services; certain home health services; services furnished by rural health clinics, ambulatory surgical centers and comprehensive outpatient rehabilitation facilities; and certain other items or medical and hospital health services not covered by the Medicare Hospital Insurance program (Part A).

B. Use of Carriers

1. Statutory basis. Under section 1842(a) of the Social Security Act (the Act), public and private organizations and agencies may participate in the administration of the Medicare program under contracts entered into with the Secretary. These Medicare contractors, known as ''carriers,'' process and pay Part B claims.

Usually, these payments are made on a claim-by-claim basis. Regulations at 42 CFR part 421, subpart C—Carriers, set forth the functions performed by Medicare carriers, which include the following:

- Determining the eligibility status of a beneficiary.
- Determining whether the services for which payment is claimed are covered under Medicare, and if so, the correct payment amounts.
- Making correct payment to the beneficiary or the supplier of the items or services, as appropriate.

Carriers must also observe the ''prompt payment'' requirements set forth in section 1842(c) of the Act. As amended by section 13568 of the Omnibus Budget Reconciliation Act of 1993 (OBRA '93) (Public Law 103–66), enacted on August 10, 1993, this provision currently requires interest to be paid on all ''clean'' claims for which payment is not issued within 30 calendar days.

2. Advance payments to suppliers. Under Part B, a carrier may make an advance partial payment to a supplier if the carrier is not able to process a claim. (For purposes of the Medicare program, § 400.202 defines ''supplier'' as a physician or other practitioner, or an entity other than a provider, that furnishes health care services under Medicare. Section 400.202 defines ''services'' as medical care or services and items, such as medical diagnosis and treatment, drugs and biologicals, supplies, appliances, and equipment, medical social services, and use of the facilities of a hospital, a rural primary care hospital, or a skilled nursing facility.) An advance payment may be made to a supplier eligible to receive Medicare payments.

At the present time, there are no regulations or guidelines for making advance payments. In rare instances, such as when major administrative changes are made in processing Part B claims, a backlog of pending claims may occur. To avoid or reduce the payment of interest on claims that are not processed timely, we sometimes authorize advance payments for pending backlogged claims, subject to later recoupment from amounts we owe, once the claims are processed.

II. General Accounting Office Report Finding—''HCFA Should Improve Internal Controls Over Part B Advance Payments''

As a result of administrative changes made in processing Part B claims at two carriers in two States during 1988, a large backlog of pending claims occurred. In order to minimize the effects of these claims payment disruptions on suppliers, in 1989 we authorized the two carriers to make advance payments for pending backlogged claims, subject to later recoupment, once the claims were actually processed. The difficulties experienced by the suppliers resulted in the General Accounting Office investigating these two carriers and their claims processing systems. This investigation led the General Accounting Office to question whether we had sufficient guidelines and safeguards in place to ensure that advance payments were promptly recouped. A full report of the General Accounting Office findings is included in the proposed rule published in the Federal Register on July 18, 1994 (59 FR 36415).

As a result of its review of these cases, the General Accounting Office recommended that we determine whether it is appropriate for carriers to make advance payments to suppliers and that we be in compliance with the Federal Managers' Financial Integrity Act (31 U.S.C. 3512) when making these determinations. A full discussion of the requirements of the Federal Managers' Financial Integrity Act was included in the proposed rule (59 FR 36416).

In applying this standard to Part B advance payments, the General Accounting Office expressed the opinion that HCFA, rather than the carriers, should authorize advance payments to be executed by the carriers. In addition, the General Accounting Office asserted that we should clearly communicate to carriers our approval to make advance payments and include the terms under which these payments must be made. Therefore, the General Accounting Office recommended that we develop regulations and instructions for carriers regarding Part B advance payments to suppliers. (General Accounting Office report, GAO/HRD–91–81 (April 1991), entitled ''Medicare: HCFA Should Improve Internal Controls Over Part B Advance Payments.'')

III. Summary of the Proposed Regulations

We published a proposed rule in the Federal Register on July 18, 1994 (59 FR 36415) to announce our intention to establish requirements and procedures for advance payments to suppliers of Medicare Part B services. The proposed rule responded to the General Accounting Office report and recommendation and proposed to add § 421.214 (''Advance payments to suppliers furnishing items or services under Part B'') to 42 CFR part 421, subpart C.

Proposed § 421.214 would ensure the smooth and uniform issuance and recoupment of Part B advance payments that may be authorized from time to time to counter the negative consequences of disruptions in Medicare Part B claims processing. The regulation, as proposed, would be entirely self-contained. Advance payments would be made when a carrier is unable to process a claim timely, not when delay is the result of late or incomplete submittal of a claim by a supplier. Processing delays would be highlighted to us to ensure that payment disruptions and risks to the Medicare trust fund would be minimized.

There are some entities with provider agreements under section 1866 of the Act that are paid for certain Part B services from the Part B Trust Fund through intermediaries (performing as a carrier when making Part B payments). These providers generally have access to the existing accelerated payment provisions under § 413.64(g). The purpose of the proposed regulation is to create a Part B advance payment procedure for suppliers, not to supplant the existing Part A advance payment procedure for some providers. Therefore, this section would not apply to claims for Part B items or services that are furnished by entities with provider agreements under section 1866 of the Act that receive payments from intermediaries.

Proposed § 421.214(b) defines the term ''advance payment'' to mean a carrier's conditional partial payment to a supplier on a Part B claim that the carrier is unable to process within the prescribed time limits.

Proposed § 421.214(c) specifies that an advance payment may be made if the carrier is unable to process claims timely; if we determine that the prompt payment interest provision in section 1842(c) of the Act is insufficient to make claimants whole; and, if the advance payment is expressly approved by us in writing. The prompt payment interest provision currently requires us to pay interest on clean claims when the carrier is unable to make payment within 30 calendar days. The determination to issue advance payments must take into consideration elements that are, or may be, subject to changes, such as legislation related to prompt payment; system enhancements; severity of system malfunctions; changes to regulations; change in contractors; and any number of other factors that may necessitate the issuance of advance payments. Therefore, we stated we would implement the threshold criterion or criteria through manual instructions to the carriers. This would give us the flexibility to respond promptly to providers without going through the rulemaking process each time a unique situation occurs. We specifically requested public comments on this approach. In making changes, we would ensure that advance payments would be made in a way that would ensure budget neutrality.

Section 421.214(d) specifies that no advance payment would be made to any supplier who is delinquent in repaying a Medicare overpayment, or one that has been advised that it is under active medical review or program integrity investigation. Also, an advance payment would not be made to a supplier that has not submitted any claims, or has not accepted claims' assignments within the most recent 180-day period preceding the system malfunction that created the need for the advance payment.

Proposed § 421.214(e)(1) specifies that a supplier must request, in writing to the carrier, an advance payment for providing Part B services. Paragraph

(e)(2) specifies that a supplier must accept an advance payment as a conditional payment subject to adjustment, recoupment, or both based on an eventual determination of the actual amount due on the claim and subject to the other rules found in § 421.214.

Proposed § 421.214(f)(1) states that a carrier must calculate an advance payment for a specific claim at no more than 80 percent of the historical assigned claims payment data paid a supplier. ''Historical data'' are defined as a representative 90-day assigned claims payment trend within the most recent 180-day experience before the system malfunction. Based on this amount, the carrier must determine and issue an advance payment on a particular claim not to exceed 80 percent of the average per claim amount paid during the 90-day trend period. If historical data are not available or if backlogged claims cannot be identified, the carrier would determine and issue advance payments based on some other methodology approved by us. Advance payments would be made no more frequently than once every 2 weeks to a supplier.

Proposed § 421.214(f)(2) specifies that generally, a supplier would not receive advance payments for more assigned claims than were paid, on a daily average, for the 90 days before the system malfunction. This would prevent and discourage suppliers from submitting assigned claims that may lack merit in order to maximize the receipt of advance payments. However, an example of a permissible exception would be when a supplier does not receive payments from a carrier for services during the early months of the year when beneficiary deductibles are being met. In this case, the carrier would use more representative payment months for the suppliers' daily average.

Proposed § 421.214(f)(3) specifies that a carrier must recover an advance payment by applying it against the amount due on the claim on which the advance payment was made. Under the proposal, if the advance payment exceeds the Medicare payment amount, the carrier must apply the unadjusted balance of the advance payment against further Medicare payments due the supplier.

It is not our intent to permit repayment of an advance payment by an option that could delay the recovery process or that would create a duplicate payment or an overpayment. Thus, a supplier of Part B services could not elect to receive the full payment amount for a claim and repay the advance payment separately at some other time.

Proposed § 421.214(f)(4) specifies that in accordance with our instructions, a carrier must maintain financial records in accordance with the Statement of Federal Financial Accounting Standards for tracking each advance payment and its recoupment.

Proposed § 421.214(g)(1) permits us to waive the requirements of paragraph (e)(1) if we determine it is appropriate to make advance payments to all affected suppliers. Paragraph (g)(2) specifies that if adjusting Medicare payments fails to recover an advance payment, we may authorize the use of any other recoupment method available (for example, lump sum repayment or an extended repayment schedule). Paragraph (g)(2) also allows an unpaid balance from a past advance payment to be converted into an overpayment. In the unlikely event that, after the adjustment process is completed, more money has been advanced to the supplier than was due, we would consider that amount to be an overpayment. We could then attempt to recover the overpayment under the Medicare recovery procedures in part 401, subpart F and part 405, subpart C.

Proposed § 421.214(h) clarifies that the advance payment would be considered a payment that would satisfy the ''prompt payment'' requirements of section 1842(c)(2) of the Act for the amount of the advance. Therefore, if an advance payment is made before the ''prompt payment'' time limit and the actual amount of payment for the claim is determined after the time limit, interest would be paid only on the balance due the supplier after the carrier deducts the amount of the advance. (Of course, no interest would accrue if the amount of the advance exceeds the actual payment amount to be made on the claim.) If the advance payment is issued after the time limit for making a prompt payment, interest would accrue on the advance (or on the amount of the claim, whichever is smaller) up to the date that the advance payment is issued, and on the balance due the supplier, if any, up to the date of payment.

Proposed § 421.214(i) explains that the decision to advance payments and the determination of the amount to be advanced on any given claim are committed to agency discretion and are not subject to review or appeal. However, the carrier would notify the supplier receiving the advance payment about the amounts advanced and recouped, and how any Medicare payment amounts have been adjusted. If the supplier believes the carrier's reconciliation of the amounts advanced and recouped is incorrectly computed, it may request an administrative review from the carrier. If a review is requested, the carrier would provide a written explanation of the adjustments. This review and explanation would be separate from a supplier's right to appeal the amount and computation of benefits paid on the claim, as provided at 42 CFR part 405, subpart H. The carrier's reconciliation of amounts advanced and recouped would not be an initial determination as defined at § 405.803, and any written explanation of this reconciliation would not be subject to further administrative review. We expect that this review process would help to eliminate unnecessary appeals that might result from errors in computation.

IV. Analysis of Public Comments

In response to the July 1994 proposed rule, we received three timely items of correspondence. Comments were received from two national trade associations—one is a nonprofit association comprised of over 2,100 home medical equipment suppliers and one represents over 850 wholesale and retail distributors of health and medical products. The third comment was sent by a 30,000-member professional association representing pharmacists in various health settings. These comments and our responses are discussed below.

Comment: One commenter stated that the term ''established time limit'' that is referenced in the definition of advance payment (§ 421.214(b)) should be specific for purposes of this rule. The commenter suggested that after 30 to 60 days, interest should be paid by the carrier on outstanding claims and after 60 days, advance payments should be made automatically.

Response: Carriers must adhere to the ''prompt payment'' requirements set forth in section 1842(c) of the Act. As amended by section 13568 of OBRA '93, this provision currently requires interest to be paid on all ''clean'' claims for which payment is not made within 30 calendar days. We expect that the need for advance payment would be determined in much less than 60 days. Additionally, as outlined in § 421.214(c) (''When advance payments may be made'') and § 421.214(d) (''When advance payments are not made''), advance payments will be paid when the requirements of the rule are met. However, it would be presumptuous for us or the carrier to assume that all suppliers would want an advance payment.

Comment: Two commenters stated that it should be the obligation of the carrier to notify suppliers as soon as the carrier discovers that payment would not be made in a timely manner and

advance payments would be necessary. One of the commenters suggested that, after an initial request, suppliers should not have to request an advance payment in writing each time an advance payment is warranted.

Response: We agree that the carrier should notify a supplier when there is a need to make advance payment. If the reason for not making prompt payment is associated with the carriers' inability to process Medicare claims in a timely manner, the carrier will notify the supplier. The supplier will have the option of receiving an advance payment, as long as the conditions as outlined in this final rule are met. Additionally, it is not our intention to require suppliers to request an advance payment each time a claim is submitted during a period that advance payments are deemed to be necessary. Advance payments will be automatic until the condition that caused the need for advance payments is corrected.

Comment: One commenter disagreed with our position that the decision to advance payments and the determination of the amount of any advance payment are committed to agency discretion and are not subject to review or appeal (§ 421.214(i)). The commenter believed that this position does not ensure more efficient and effective administration of this aspect of the Medicare program.

Response: Advance payments are discretionary because the Medicare statute imposes no obligation to advance these monies before a final payment determination is made. The final payment determination is not affected by the advance payment process; suppliers can only be advantaged by receiving these advances. Agency discretion for the amount to be advanced is based on a valid and fair formula, as outlined in § 421.214(f)(1) and (f)(2). This is an efficient and effective administration of the program that minimizes the risks to the Medicare trust fund, without prejudice to the supplier.

Comment: One commenter objected to the provision in the proposed rule instructing a carrier that the amount of an advance payment should be no more than 80 percent of the historical assigned claims payment data (§ 421.214(f)(1)). The commenter believed the supplier should get an advance payment of 100 percent of its submitted charges, minus the supplier's historical percentage differential between submitted and approved charges.

Response: We have determined that the fairest method of calculating advance payments to suppliers without risking an overpayment is to calculate an advance payment for a particular claim at no more than 80 percent of the anticipated payment for that claim based upon the historical assigned claims payment data for claims paid to the supplier. This payment methodology balances the financial needs of the supplier with our responsibility to protect the Medicare trust fund.

Comment: One commenter was concerned that a provision in the proposed rule (§ 421.214(f)(3)) would allow the carrier to recover payment from the supplier without requiring the carrier to resolve the problem that actually caused the claims processing problem.

Response: The commenter's concern is unfounded. It is not our intent to recover any part of the advance payment before the carrier resolves the problem that made the advance payment necessary.

Comment: One commenter recommended that the supplier be given the opportunity to repay the advance payment by check or wire transfer to avoid the offsetting against claims because offsetting claims often results in accounting problems.

Response: Permitting suppliers to refund advance payments (as opposed to having the advanced payment offset against the actual payment amount) would undoubtedly produce systemic overpayments and duplicate payments to suppliers. This would be directly contrary to the intent and purpose of this final rule. It is not our intent to permit repayment of an advance payment by an option that could delay the recovery process or that will create a duplicate payment or an overpayment. A supplier of Part B services could not elect to receive full payment for a claim and repay the advance payment separately at some other time. Permitting suppliers to refund the advance payment by check or wire transfer also conflicts with the definition of ''advance payment'' in § 421.214(b) and the concept of advancing a portion of what is owed. The recommendation by the commenter would, in all probability, increase the frequency of overpayments and duplicate payments to providers, could be prone to abuse, and is inconsistent with the intent of this rule.

Comment: One commenter had concerns about the provision prohibiting an advance payment to a supplier if the supplier is under active medical review or undergoing a program integrity investigation (§ 421.214(d)(2)). The same commenter also believed that suppliers that do not take assignment should not be excluded from receiving a cash advance (§ 421.214(d)(4)).

Response: A supplier that is under an active medical review or undergoing a program integrity investigation is in a status that we do not treat lightly. These reviews and investigations could culminate in actions that result in civil, criminal, and administrative remedies. To authorize an advance payment without final resolution of the medical review or program integrity investigation is not in the best interest of the Medicare trust fund. A supplier that does not accept assignment receives no monies from Medicare. Therefore, there is no basis for an advance payment.

Comment: One commenter suggested that within 3 business days of a carrier's receipt of an advance payment request, the carrier should inform the supplier in writing of the amount of the advance payment and, within the following 5 business days, the carrier should forward a check for the advance payment to the supplier.

Response: The commenter proposes an administratively burdensome time frame for carrier action that is far shorter than (and inconsistent with) the ''prompt payment'' standard for ''clean'' claims provided by Congress in section 1842(c)(2) of the Act. In accordance with this provision, we pay interest when the carrier does not pay a claim within 30 calendar days of receipt. Under 421.214(b), we will issue advance payments only if the carrier is unable to process claims timely, that is, within this 30 day period. Once we decide that the carrier should issue advance payments, continuing advance payments will be timed to be consistent with these prompt payment rules and the carrier's usual operating procedures. This should minimize the obligation to pay interest, as well as reduce the administrative burden on the carrier during difficult circumstances. In addition, to adopt the commenter's suggestion would likely aggravate the situation because it would appear to create an incentive to seek advance payments.

Comment: One commenter stated that it opposed our proposed method of calculating the amount of the advance payment (§ 421.214(f)) if the payment is based on 80 percent of assigned claims submitted in the past 90 days. The commenter further stated that if a carrier is unable to process claims, the advance payment provision should allow that carrier to pay at 100 percent of the supplier's submitted charges, minus the supplier's historical percentage differential between submitted and approved charges.

Response: We chose to base the advance payment on 80 percent of assigned claims submitted in the past 90 days to meet the needs of a supplier to continue to be a viable business and our responsibility to protect the Medicare trust fund. If we chose to base the advance payment on 100 percent of its submitted charges, minus the supplier's historical percentage differential between submitted and approved charges, we would likely create a situation in which a carrier overpays a supplier and subsequently must recover the overpayment. This situation creates an administrative burden on the carrier to develop procedures to recover the overpayment successfully and results in increased costs to the Medicare program.

V. Provisions of the Final Rule

We are making the following changes in this final rule as a result of written comments received on the proposed rule. We are adding the following paragraph (1) at the beginning of § 421.214(f), which concerns requirements for carriers:

''(1) A carrier must notify a supplier as soon as it is determined that payment will not be made in a timely manner, and an advance payment option is to be offered to the supplier.''

We are also clarifying § 421.214(f)(1)(i) to eliminate possible uncertainty regarding how advance payments will be calculated.

VI. Collection of Information

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 requires that we solicit comment on the following issues:

- Whether the information collection is necessary and useful to carry 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 § 421.214(f)(4) of this document that contains information collection requirements. The information collection in that section requires carriers to maintain a system of financial data in accordance with the Statement of Federal Financial Accounting Standards for tracking each advance payment and its recoupment. We estimate that it will take a carrier 4 minutes for entry of an advance payment into the tracking system and 2 minutes for any update (including recoupment).

For comments that relate to information collection requirements, mail a copy of comments to: Health Care Financing Administration, Office of Financial and Human Resources, Management Planning and Analysis Staff, Room C2–26–17, 7500 Security Boulevard, Baltimore, Maryland 21244–1850.

VII. Regulatory Impact Statement

Consistent with the Regulatory Flexibility Act (RFA) (5 U.S.C. 601 through 612), we prepare a regulatory flexibility analysis unless the Secretary certifies that a rule will not have a significant economic impact on a substantial number of small entities. For purposes of the RFA, we consider all suppliers that provide services under Medicare Part B to be small entities. We do not consider carriers to be small entities.

Also, section 1102(b) of the Act requires the Secretary to prepare a regulatory impact analysis for any rule that may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 50 beds.

This final rule amends Medicare regulations to ensure that if carriers make advance payments to suppliers and those payments are greater than the amounts actually due after the claim is processed, the excess payments are recovered promptly. We expect this rule will result in marginal administrative savings to carriers and suppliers. In addition, we do not believe this regulation will have a negative effect on the economy. Therefore, the overall benefits are positive and indeed provide stability for suppliers during potentially disruptive claims processing delays.

We have determined, and we certify, that this final rule will not have a significant economic impact on a substantial number of small entities or a significant impact on the operations of a substantial number of small rural hospitals. Therefore, we have not prepared analyses for either the RFA or section 1102(b) of the Act.

In accordance with the provisions of Executive Order 12866, this regulation was not reviewed by the Office of Management and Budget.

This rule is not a major rule as defined at 5 U.S.C. 804(2).

List of Subjects in 42 CFR Part 421

Administrative practice and procedure, Health facilities, Health professions, Medicare, Reporting and recordkeeping requirements.

42 CFR part 421 is amended as follows:

PART 421—INTERMEDIARIES AND CARRIERS

1. The authority citation for part 421 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

Subpart C—Carriers

2. A new § 421.214 is added to subpart C to read as follows:

§ 421.214 Advance payments to suppliers furnishing items or services under Part B.

(a) *Scope and applicability.* This section provides for the following:

(1) Sets forth requirements and procedures for the issuance and recovery of advance payments to suppliers of Part B services and the rights and responsibilities of suppliers under the payment and recovery process.

(2) Does not limit HCFA's right to recover unadjusted advance payment balances.

(3) Does not affect suppliers' appeal rights under part 405, subpart H of this chapter relating to substantive determinations on suppliers' claims.

(4) Does not apply to claims for Part B services furnished by suppliers that have in effect provider agreements under section 1866 of the Act and part 489 of this chapter, and are paid by intermediaries.

(b) *Definition.* As used in this section, *advance payment* means a conditional partial payment made by the carrier in response to a claim that it is unable to process within established time limits.

(c) *When advance payments may be made.* An advance payment may be made if all of the following conditions are met:

(1) The carrier is unable to process the claim timely.

(2) HCFA determines that the prompt payment interest provision specified in section 1842(c) of the Act is insufficient to make a claimant whole.

(3) HCFA approves, in writing to the carrier, the making of an advance payment by the carrier.

(d) *When advance payments are not made.* Advance payments are not made to any supplier that meets any of the following conditions:

(1) Is delinquent in repaying a Medicare overpayment.

(2) Has been advised of being under active medical review or program integrity investigation.

(3) Has not submitted any claims.

(4) Has not accepted claims' assignments within the most recent 180-day period preceding the system malfunction.

(e) *Requirements for suppliers.* (1) Except as provided for in paragraph (g)(1) of this section, a supplier must request, in writing to the carrier, an advance payment for Part B services it furnished.

(2) A supplier must accept an advance payment as a conditional payment subject to adjustment, recoupment, or both, based on an eventual determination of the actual amount due on the claim and subject to the provisions of this section.

(f) *Requirements for carriers.* (1) A carrier must notify a supplier as soon as it is determined that payment will not be made in a timely manner, and an advance payment option is to be offered to the supplier.

(i) A carrier must calculate an advance payment for a particular claim at no more than 80 percent of the anticipated payment for that claim based upon the historical assigned claims payment data for claims paid the supplier.

(ii) ''Historical data'' are defined as a representative 90-day assigned claims payment trend within the most recent 180-day experience before the system malfunction.

(iii) Based on this amount and the number of claims pending for the supplier, the carrier must determine and issue advance payments.

(iv) If historical data are not available or if backlogged claims cannot be identified, the carrier must determine and issue advance payments based on some other methodology approved by HCFA.

(v) Advance payments can be made no more frequently than once every 2 weeks to a supplier.

(2) Generally, a supplier will not receive advance payments for more assigned claims than were paid, on a daily average, for the 90-day period before the system malfunction.

(3) A carrier must recover an advance payment by applying it against the amount due on the claim on which the advance was made. If the advance payment exceeds the Medicare payment amount, the carrier must apply the unadjusted balance of the advance payment against future Medicare payments due the supplier.

(4) In accordance with HCFA instructions, a carrier must maintain a financial system of data in accordance with the Statement of Federal Financial Accounting Standards for tracking each advance payment and its recoupment.

(g) *Requirements for HCFA.* (1) In accordance with the provisions of this section, HCFA may determine that circumstances warrant the issuance of advance payments to all affected suppliers furnishing Part B services. HCFA may waive the requirement in paragraph (e)(1) of this section as part of that determination.

(2) If adjusting Medicare payments fails to recover an advance payment, HCFA may authorize the use of any other recoupment method available (for example, lump sum repayment or an extended repayment schedule) including, upon written notice from the carrier to the supplier, converting any unpaid balances of advance payments to overpayments. Overpayments are recovered in accordance with part 401, subpart F of this chapter concerning claims collection and compromise and part 405, subpart C of this chapter concerning recovery of overpayments.

(h) *Prompt payment interest.* An advance payment is a ''payment'' under section 1842(c)(2)(C) of the Act for purposes of meeting the time limit for the payment of clean claims, to the extent of the advance payment.

(i) *Notice, review, and appeal rights.* (1) The decision to advance payments and the determination of the amount of any advance payment are committed to HCFA's discretion and are not subject to review or appeal.

(2) The carrier must notify the supplier receiving an advance payment about the amounts advanced and recouped and how any Medicare payment amounts have been adjusted.

(3) The supplier may request an administrative review from the carrier if it believes the carrier's reconciliation of the amounts advanced and recouped is incorrectly computed. If a review is requested, the carrier must provide a written explanation of the adjustments.

(4) The review and explanation described in paragraph (i)(3) of this section is separate from a supplier's right to appeal the amount and computation of benefits paid on the claim, as provided at part 405, subpart H of this chapter. The carrier's reconciliation of amounts advanced and recouped is not an initial determination as defined at § 405.803 of this chapter, and any written explanation of a reconciliation is not subject to further administrative review.

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

Dated: August 30, 1996.

Bruce C. Vladeck,

Administrator, Health Care Financing Administration.

[FR Doc. 96–23958 Filed 9–18–96; 8:45 am]

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DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

50 CFR Part 648

[Docket No. 960216032–6246–07; I.D. 082096H]

RIN 0648–AH70

Fisheries of the Northeastern United States; Northeast Multispecies Fishery; Exception to Permit Requirements

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

ACTION: Final rule with request for comments.

SUMMARY: NMFS issues this final rule to modify the regulations implementing the Northeast Multispecies Fishery Management Plan. This rule allows vessels fishing exclusively with pot gear, which are not otherwise allowed to possess multispecies finfish, to possess multispecies frames as bait, provided that a receipt for purchase of that specific bait is on board the vessel. The intended effect is to allow the current practice of using multispecies frames as bait in the pot gear fishery to continue.

DATES: This rule is effective September 13, 1996. Comments must be received on or before October 15, 1996.

ADDRESSES: Comments on the rule should be sent to Dr. Andrew A. Rosenberg, Regional Director, NMFS, Northeast Regional Office, 1 Blackburn Drive, Gloucester, MA 01930, Attention: Susan A. Murphy.

FOR FURTHER INFORMATION CONTACT: Susan A. Murphy, NMFS, Fishery Policy Analyst, 508–281–9252.

SUPPLEMENTARY INFORMATION: Amendment 7 to the FMP, effective on July 1, 1996 (61 FR 27710, May 31, 1996), implemented comprehensive