(e) Prospective payment system amount defined. In this section, the term “prospective payment system amount” means, with respect to covered hospital outpatient services, the amount payable under this part for these services (determined without regard to this section or any reduction in coinsurance elected under §419.41), including amounts payable as copayment under §419.41, coinsurance under section 1866(a)(2)(A)(ii) of the Act, and the deductible under section 1833(b) of the Act.

(f) Pre-BBA amount defined—(1) General rule. In this paragraph, the “pre-BBA amount” means, with respect to covered hospital outpatient services furnished by a hospital or a community mental health center (CMHC) in a year, an amount equal to the product of the reasonable cost of the provider for these services for the portions of the provider’s cost reporting period (or periods) occurring in the year and the base provider outpatient payment-to-cost ratio for the provider (as defined in paragraph (f)(2) of this section).

(2) Base payment-to-cost-ratio defined. For purposes of this paragraph, CMS shall determine these ratios as if the amendments to sections 1833(i)(3)(B)(i)(II) and 1833(n)(1)(B)(i) of the Act made by section 4521 of the BBA, to require that the full amount beneficiaries paid as coinsurance under section 1862(a)(2)(A) of the Act are taken into account in determining Medicare Part B Trust Fund payment to the hospital, were in effect in 1996. The “base payment-to-cost ratio” for a hospital or CMHC means the ratio of—

(i) The provider’s payment under this part for covered outpatient services furnished during one of the following periods, including any payment for these services through cost-sharing described in paragraph (e) of this section:

(A) The cost reporting period ending in 1996; or

(B) If the provider does not have a cost reporting period ending in 1996, the first cost reporting period ending on or after January 1, 1997, and before January 1, 2001; and

(ii) The reasonable costs of these services for the same cost reporting period.

(g) Interim payments. CMS makes payments under this section to hospitals and CMHCs on an interim basis, subject to retrospective adjustments based on settled cost reports.

(h) No effect on coinsurance. No payment made under this section affects the unadjusted coinsurance amount or the coinsurance amount described in §419.41.

(i) Application without regard to budget neutrality. The additional payments made under this section—

(1) Are not considered an adjustment under §419.43(f); and

(2) Are not implemented in a budget neutral manner.

§ 420.304 Procedures for obtaining access to books, documents, and records.

Subpart E—Rewards for Information Relating to Medicare Fraud and Abuse, and Establishment of a Program to Collect Suggestions for Improving Medicare Program Efficiency and to Reward Suggesters for Monetary Savings

§ 420.400 Basis and scope.

§ 420.405 Rewards for information relating to Medicare fraud and abuse.

§ 420.410 Establishment of a program to collect suggestions for improving Medicare program efficiency and to reward suggesters for monetary savings.

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

SOURCE: 44 FR 31142, May 30, 1979, unless otherwise noted.

Subpart A—General Provisions

§ 420.1 Scope and purpose.

This part sets forth requirements for Medicare providers, intermediaries, and carriers to disclose ownership and control information. It also deals with access to records pertaining to certain contracts entered into by Medicare providers. These rules are aimed at protecting the integrity of the Medicare program. The statutory basis for these requirements is explained in each of the other subparts.

[51 FR 34787, Sept. 30, 1986]

§ 420.3 Other related regulations.

(a) Appeals procedures. Part 498 of this chapter sets forth the appeals procedures available to providers whose provider agreements CMS terminates for failure to comply with the disclosure of information requirements set forth in subpart C of this part.

(b) Exclusion, termination, or suspension. Part 1001 of this title sets forth the rules applicable to exclusion, termination, or suspension from the Medicare program because of fraud or abuse or conviction of program-related crimes.


Subpart B [Reserved]
Managing employee means a general manager, business manager, administrator, director, or other individual that exercises operational or managerial control over, or who directly or indirectly conducts, the day-to-day operation of the institution, organization, or agency, either under contract or through some other arrangement, whether or not the individual is a W-2 employee.

Other disclosing entity means any other Medicare disclosing entity and any entity that does not participate in Medicare, but is required to disclose certain ownership and control information because of participation in any of the programs established under title V, XIX, or XX of the Act. This includes:

1. An entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, items or services for which payment may be claimed by the entity under any plan or program established under title V of the Social Security Act or under an approved State Medicaid plan;
2. An entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which payment may be claimed by the entity under an approved State plan and services program under title XX of the Act; or
3. A Medicaid fiscal agent.

Ownership interest means the possession of equity in the capital, the stock, or the profits of the disclosing entity.

Person with an ownership or control interest means a person or corporation that—

1. Has an ownership interest totaling 5 percent or more in a disclosing entity;
2. Has an indirect ownership interest equal to 5 percent or more in a disclosing entity;
3. Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity;
4. Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity;
5. Is an officer or director of a disclosing entity that is organized as a corporation; or
6. Is a partner in a disclosing entity that is organized as a partnership.

Significant business transaction means any business transaction or series of transactions during any one fiscal year, the total of which exceeds the lesser of $25,000 and 5 percent of the total operating expenses of the provider.

Subcontractor means—

1. An individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or
2. An individual, agency, or organization with which an intermediary or carrier has entered into a contract, agreement, purchase order or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicare agreement.

Wholly owned supplier means a supplier whose total ownership interest is held by a provider or by a person, persons, or other entity with an ownership or control interest in a provider.

§ 420.202 Determination of ownership or control percentages.

(a) Indirect ownership interest. The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity. For example, if A owns 10 percent of the stock in a corporation that owns 80 percent of the disclosing entity, A’s interest equates to an 8 percent indirect ownership interest in the disclosing entity and must be reported. Conversely, if B owns 80 percent of the stock of a corporation that owns 5 percent of the stock of the disclosing entity, B’s interest equates to a 4 percent indirect ownership interest in the disclosing entity and need not be reported.

(b) Person with an ownership or control interest. In order to determine the percentage of ownership interest in any mortgage, deed of trust, note, or other obligation, the percentage of interest
owned in obligation is multiplied by the percentage of the disclosing entity’s assets used to secure the obligation. For example, if A owns 10 percent of a note secured by 60 percent of the provider’s assets, A’s interest in the provider’s assets equals to 6 percent and must be reported. Conversely, if B owns 40 percent of a note secured by 10 percent of the provider’s assets, B’s interest in the provider’s assets equals to 4 percent and need not be reported.

§ 420.203 Disclosure of hiring of intermediary’s former employees.

A provider must notify the Secretary promptly if it, or its home office (in the case of a chain organization), employs or obtains the services of an individual who, at any time during the year preceding such employment, was employed in a managerial, accounting, auditing, or similar capacity by an agency or organization which currently serves, or at any time during the preceding year, served as a Medicare fiscal intermediary or carrier for the provider. Similar capacity means the performance of essentially the same work functions as those of a manager, accountant, or auditor even though the individual is not so designated by title.

§ 420.204 Principals convicted of a program-related crime.

(a) Information required. Prior to CMS’s acceptance of a provider agreement or issuance or reissuance of a supplier billing number, or at any time upon written request by CMS, the provider or part B supplier must furnish CMS with the identity of any person who:

(1) Has an ownership or control interest in the provider or part B supplier;

(2) Is an agent or managing employee of the provider or part B supplier; or

(3) Is a person identified in paragraph (a)(1) or (a)(2) of this section and has been convicted of, or was an owner of, had a controlling interest in, or was a managing employee of a corporation that has been convicted of a criminal offense, subjected to any civil monetary penalty, or excluded from the programs for any activities related to involvement in the Medicare, Medicaid, title V or title XX social services programs, since the inception of those programs.

(b) Refusal to enter into or renew agreement or to issue or reissue billing numbers. CMS may refuse to enter into or renew an agreement with a provider of services, or to issue or reissue a billing number to a part B supplier, if any person who has an ownership or control interest in the provider or supplier, or who is an agent or managing employee, has been convicted of a criminal offense or subjected to any civil penalty or sanction related to the involvement of that person in Medicare, Medicaid, title V or title XX social services programs. In making this decision, CMS considers the facts and circumstances of the specific case, including the nature and severity of the crime, penalty or sanction and the extent to which it adversely affected beneficiaries and the programs involved. CMS also considers whether it has been given reasonable assurance that the person will not commit any further criminal or civil offense against the programs.

(c) Notification of Inspector General. CMS promptly notifies the Inspector General of the Department of the receipt of any application or request for participation, certification, re-certification, or for a billing number that identifies any person described in paragraph (a)(3) of this section and the action taken on that application or request.

[57 FR 27306, June 18, 1992]

§ 420.205 Disclosure by providers and part B suppliers of business transaction information.

A provider or part B supplier must submit to CMS, within 35 days after the date of a written request, full and complete information on—

(a) The ownership of a subcontractor with which the provider or part B supplier has had, during the previous 12 months, business transactions in an aggregate amount in excess of $25,000;

(b) Any significant business transactions between the provider or part B supplier and any wholly owned supplier or between the provider or part B supplier and any subcontractor, during the 5 year period ending on the date of the request;
§ 420.206 Disclosure of persons having ownership, financial, or control interest.

(a) Information that must be disclosed. A disclosing entity must submit the following information in the manner specified in paragraph (b) of this section:

(1) The name and address of each person with an ownership or control interest in the entity or in any subcontractor in which the entity has direct or indirect ownership interest totaling 5 percent or more. In the case of a part B supplier that is a joint venture, ownership of 5 percent or more of any company participating in the joint venture should be reported. Any physician who has been issued a Unique Physician Identification Number by the Medicare program must provide this number.

(2) Whether any of the persons named, in compliance with paragraph (a)(1) of this section, is related to another as spouse, parent, child, or sibling.

(3) The name of any other disclosing entity in which any person with an ownership or control interest, or who is a managing employee in the reporting disclosing entity, has, or has had in the previous three-year period, an ownership or control interest or position as managing employee, and the nature of the relationship with the other disclosing entity. If any of these other disclosing entities has been convicted of a criminal offense or received a civil monetary or other administrative sanction related to participation in Medicare, Medicaid, title V (Maternal and Child Health) or title XX (Social Services) programs, such as penalties assessments and exclusions under sections 1128, 1128A or 1128B of the Act, the disclosing entity must also provide that information.

(b) Time and manner of disclosure. (1) Any disclosing entity that is subject to periodic survey and certification of its compliance with Medicare standards must supply the information specified in paragraph (a) of this section to the State survey agency at the time it is surveyed. The survey agency will promptly furnish the information to the Secretary.

(2) Any disclosing entity that is not subject to periodic survey and certification must supply the information specified in paragraph (a) of this section to CMS before entering into a contract or agreement with Medicare or before being issued or reissued a billing number as a part B supplier.

(3) A disclosing entity must furnish updated information to CMS at intervals between recertification, or re-enrollment, or contract renewals, within 35 days of a written request. In the case of a part B supplier, the supplier must report also within 35 days, on its own initiative, any changes in the information it previously supplied.

(c) Consequences of failure to disclose. (1) CMS does not approve an agreement or contract with, or make a determination of eligibility for, or (in the case of a part B supplier) issue or reissue a billing number to, any disclosing entity that fails to comply with paragraph (b) of this section.

(2) CMS terminates any existing agreement or contract with, or withdraws a determination of eligibility for, or (in the case of a part B supplier) revokes the billing number of, any disclosing entity that fails to comply with paragraph (b) of this section.

(d) Public disclosure. Information furnished to the Secretary under the provisions of this section shall be subject to public disclosure as specified in 20 CFR part 422.

[44 FR 41642, July 17, 1979, as amended at 57 FR 27306, June 18, 1992]
§ 420.300

Subpart D—Access to Books, Documents, and Records of Subcontractors

SOURCE: 47 FR 58267, Dec. 30, 1982, unless otherwise noted.

§ 420.300 Basis, purpose, and scope.

This subpart implements section 1861(v)(1)(I) of the Act, which requires, for Medicare payment under certain provider contracts, access by the Secretary, upon written request, and the Comptroller General, and their duly authorized representatives, to certain contracts for services and to books, documents, and records necessary to verify the costs of the services. The contracts affected are those between providers and their subcontractors, and between the subcontractors and organizations related to the subcontractor by control or common ownership. It also specifies the criteria by which HHS will determine whether to request access to books, documents, and records.

§ 420.301 Definitions.

For purposes of this subpart—

Books, documents, and records means all writings, recordings, transcriptions and tapes of any description necessary to verify the nature and extent of the costs of the services provided by the subcontractor.

Common ownership means that an individual or individuals possess significant ownership or equity in the subcontractor and the entity providing the services under the contract.

Contract for services means a contract through which a provider obtains the performance of an act or acts, as distinguished from supplies or equipment. It includes any contract for both goods and services to the extent the value or cost of the service component is $10,000 or more within a 12-month period.

Control means that an individual or an organization has the power, directly or indirectly, significantly to influence or direct the actions of policies of an organization.

Provider means a hospital, skilled nursing facility, home health agency, hospice, or comprehensive outpatient rehabilitation facility, or a related organization (as defined in §413.17 of this chapter) of any of these providers.

Related to the subcontractor means that the subcontractor is, to a significant extent, associated or affiliated with, owns, or is owned by, or has control of or is controlled by, the organization furnishing the services, facilities, or supplies.

Subcontractor means any entity, including an individual or individuals, that contracts with a provider to supply a service, either to the provider or directly to a beneficiary, for which Medicare reimburses the provider for the cost of the service. This includes organizations related to the subcontractor that have a contract with the subcontractor for which the cost or value is $10,000 or more in a 12-month period.

§ 420.302 Requirement for access clause in contracts.

(a) Applicability. This subpart applies to contracts—

(1) Between a provider and a subcontractor and, where subject to section 1861(v)(1)(I)(ii) of the Act, between a subcontractor and an organization related to the subcontractor;

(2) Entered into or renewed after December 5, 1980; and

(3) For services the cost or value of which is $10,000 or more over a 12-month period, including contracts for both goods and services in which the service component is worth $10,000 or more over a 12-month period.

(b) Requirement. Any contract meeting the conditions of paragraph (a) of this section must include a clause that allows the Comptroller General of the United States, HHS, and their duly authorized representatives access to the subcontractor’s contract, books, documents, and records until the expiration of four years after the services are furnished under the contract or subcontract. The access must be provided in accordance with the provisions of this subpart. The clause must also allow similar access by HHS, the Comptroller General, and their duly authorized representatives to contracts subject to section 1861(v)(1)(I)(ii) of the Act.
Act between a subcontractor and organizations related to the subcontractor and to books, documents, and records.

(c) Prohibition against Medicare reimbursement. If a contract subject to the requirements of this subpart does not contain the clause required by paragraph (b) of this section, CMS will not reimburse the provider for the cost of the services furnished under the contract and will recoup any payments previously made for services under the contract. However, in order to avoid nonreimbursement or recoupment, providers will have until July 30, 1983, to amend those contracts entered into or renewed after December 5, 1980, and before January 31, 1983, that do not conform to the requirements of paragraph (b) of this section.


§ 420.303 HHS criteria for requesting books, documents, and records.

HHS will generally request books, documents, and records from a subcontractor only if one of the following situations exists and the question cannot satisfactorily and efficiently be resolved without access to the books, documents, and records:

(a) HHS has reason to believe that the costs claimed for services of the subcontractor are excessive or inappropriate.

(b) There is insufficient information to judge the appropriateness of the costs.

(c) There is a written accusation with suitable evidence against the provider or subcontractor of kickbacks, bribes, rebates, or other illegal activities.

(d) There is evidence of a possible nondisclosure of the existence of a related organization.

§ 420.304 Procedures for obtaining access to books, documents, and records.

(a) Contents of the request. Requests for access will be in writing and contain the following elements:

(1) Reasonable identification of the books, documents, and records to which access is being requested.

(2) Identification of the contract or subcontract in which costs are being questioned as excessive or inappropriate.

(3) The reason that the appropriateness of the costs or value of the services of the subcontractor in question cannot be adequately or efficiently determined without access to the subcontractor’s books and records.

(4) The authority in the statute and regulations for the access requested.

(5) To the extent possible, the identification of those individuals who will be visiting the subcontractor to obtain access to the books, documents, and records.

(6) The time and date of the scheduled visit.

(7) The name of the duly authorized representative of HHS to contact if there are any questions.

(b) Subcontractor response to a request for access to books, documents, and records. (1) The subcontractor will have 30 days from the date of a written request for access to books, documents, and records to make them available in accordance with the request.

(2) If the subcontractor believes the request is inadequate because it does not fully meet one or more of the required elements in paragraph (a) of this section, the subcontractor must advise the requesting organization of the additional information needed.

(i) The subcontractor must notify the requesting organization within 20 days of the date of the request that it was improperly completed.

(ii) The subcontractor must make the books, documents, and records available within 20 days after the date of the requesting organization’s response.

(3) If the subcontractor believes, for good cause, that the requested books, documents, and records cannot be made available as requested within the 30-day period under paragraph (b)(1) of this section, the subcontractor may request an extension of time within which to comply with the request from the requesting organization. The requesting organization may, at its discretion, grant the request for an extension, in whole or in part, for good cause shown.

(4) The subcontractor must make the books, documents, and records available during its regular business hours for inspection, audit, and reproduction.
§ 420.400 Basis and scope.

This subpart implements sections 203(b) and (c) of Public Law 104–191, which require the establishment of programs to encourage individuals to report suspected cases of fraud and abuse and submit suggestions on methods to improve the efficiency of the Medicare program. Sections 203(b) and (c) of Public Law 104–191 also provide the authority for CMS to reward individuals for reporting fraud and abuse and for submitting suggestions that could improve the efficiency of the Medicare program. This subpart sets forth procedures for rewarding individuals.

[64 FR 66401, Nov. 26, 1999]

§ 420.405 Rewards for information relating to Medicare fraud and abuse.

(a) General rule. CMS pays a monetary reward for information that leads to the recovery of at least $100 of Medicare funds from individuals and entities that are engaging in, or have engaged in, acts or omissions that constitute grounds for the imposition of a sanction under section 1128, section 1128A, or section 1128B of the Act or that have otherwise engaged in sanctionable fraud and abuse against the Medicare program. The determination of whether an individual meets the criteria for an award, and the amount of the award, is at the discretion of CMS. CMS pays rewards only if a reward is not otherwise provided for by law. When CMS applies the criteria specified in paragraphs (b), (c), and (e) of this section to determine the eligibility and the amount of the reward, it notifies the beneficiary as specified in paragraph (d) of this section.

(b) Information eligible for reward. (1) In order for an individual to be eligible to receive a reward, the information he or she supplied must relate to the activities of a specific individual or entity and must specify the time period of the alleged activities.

(2) CMS does not give a reward for information relating to an individual or entity that, at the time the information is provided, is already the subject of a review or investigation by CMS or its contractors, or the OIG, the Department of Justice, the Federal Bureau of Investigation, or any other Federal, State, or local law enforcement agency.

(c) Persons eligible to receive a reward—

(1) General rule. Any person (other than one excluded under paragraph (c)(2) of this section) is eligible to receive a reward under this section if the person submits the information in the manner set forth in paragraph (f) of this section.

(2) Excluded individuals. (i) An individual who was, or is an immediate family member of, an officer or employee of HHS or its contractors, the SSA, the OIG, a State Medicaid Agency, or the Department of Justice, the Federal Bureau of Investigation, or any other Federal, State, or local law enforcement agency at the time he or she came into possession of, or divulged, information leading to a recovery of Medicare funds is not eligible to receive a reward under this section.
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(ii) Any other Federal or State employee or contractor or an HHS grantee is not eligible for a reward under this section if the information submitted came to his or her knowledge in the course of his or her official duties.

(iii) An individual who illegally obtained the information he or she submitted is excluded from receiving a reward under this section.

(iv) An individual who participated in the sanctionable offense with respect to which payment would be made is excluded from receiving a reward under this section.

(d) Notification of eligibility—(1) General rule. After all Medicare funds have been recovered and CMS has determined a participant eligible to receive a reward under the provisions of this section, it notifies the informant of his or her eligibility, by mail, at the most recent address supplied by the individual. It is the individual’s responsibility to ensure that the reward program has been notified of any change in his or her address or other relevant personal information (for example, change of name, phone number).

(2) Special circumstances. (i) If the individual has relocated to an unknown address, the individual or his or her legal representative may claim the reward by contacting CMS within 1 year from the date on which CMS first attempted to notify the individual about a reward. CMS does not consider the individual or his or her legal representative eligible for a reward more than 1 year after the date on which it first attempted to give notice. CMS does not pay interest on rewards that are not immediately claimed.

(ii) If the individual has become incapacitated or has died, an executor, administrator, or other legal representative may claim the reward on behalf of the individual or the individual’s estate. The claimant must submit certified copies of the letters testamentary, letters of administration, or other similar evidence to show his or her authority to claim the reward. The claim must be filed within 1 year from the date on which CMS first gave or attempted to give notice of the reward.

(e) Amount and payment of reward. (1) In determining whether it will pay a reward and, if so, the amount of the reward, CMS takes into account all relevant factors, including the significance of the information furnished in relation to the ultimate resolution of the case and the recovery of Medicare funds.

(2) The amount of a reward represents what CMS considers to be adequate compensation in the particular case, not to exceed 10 percent of the overpayments recovered in the case or $1,000, whichever is less.

(3) If more than one person is eligible to receive a reward in a particular case, CMS allocates the total reward amount (not to exceed 10 percent of the overpayments recovered in that case or $1,000, whichever is less) among the participants.

(4) CMS bases rewards only on recovered Medicare payments and not on amounts collected as penalties or fines.

(5) CMS makes payments as promptly as the circumstances of the case permit, but not until it has collected all Medicare overpayments, fines, and penalties.

(6) No person may make any offer or promise or otherwise bind CMS or HHS with respect to the payment of any reward under this section or the amount of the reward.

(f) Submission of information. (1) An individual may submit information on persons or entities engaging in, or that have engaged in, fraud and abuse against the Medicare program to the Office of the Inspector General, or to the Medicare intermediary or carrier that has jurisdiction over the suspected fraudulent provider or supplier.

(2) A participant interested in receiving a reward must provide his or her name, address, telephone number, and any other requested identifying information so that he or she may be contacted, if necessary, for additional information and, when applicable, for the payment of a reward upon resolution of the case.

(g) Confidentiality. CMS does not reveal a participant’s identity to any person, except as required by law.

(h) Finding of ineligibility after reward is accepted. If, after a reward is accepted, CMS finds that the awardee was ineligible to receive the reward, the Government is not liable for the reward.
§ 420.410 Establishment of a program to collect suggestions for improving Medicare program efficiency and to reward suggesters for monetary savings.

(a) Definitions. As used in this section, the following definitions apply:

Payment means a monetary award given to a suggester in recognition of, and as a reward for, a suggestion adopted by CMS that improves the efficiency of, and results in monetary savings to, the Medicare program.

Savings means the monetary value of the net benefits the Medicare program derives from implementing the suggestion.

Suggester means an individual, a group of individuals, or a legal entity such as a corporation, partnership, or professional association, not otherwise excluded under § 420.410(d), who submits a suggestion under this section.

Suggestion means an original idea submitted in writing.

Suggestion program means the specific procedures and requirements established by CMS for receiving suggestions from the suggester on methods to improve the efficiency of the Medicare program, evaluating the suggestions and, if appropriate, paying a reward to the suggester for adopted suggestions that result in improved efficiency and produce monetary savings to the Medicare program.

(b) General rule. CMS may make payment for adopted suggestions that increase the efficiency of the Medicare program and result in monetary savings. CMS only makes payment for suggestions in instances in which a reward is not otherwise provided by law. The determination to adopt a suggestion, to reward the suggester, and the method of calculating a reward are at the sole discretion of CMS.

(c) Eligibility. Except as specified in paragraph (d) of this section, any individual, group of individuals or legal entity, such as a corporation, partnership or professional association, is eligible to submit a suggestion and be considered for a reward under this suggestion program if the suggestion is submitted to CMS in the manner set forth in paragraph (e) of this section.

(d) Exclusions. Medicare contractors, their officers and employees, individuals who work for Federal agencies under a contract, employees of Federally-sponsored research and demonstration projects, Federal officers and employees, and immediate family members of these individuals, are excluded from receiving payment under the suggestion program. If, after the suggester receives a reward payment, CMS determines that the suggester was ineligible to receive the reward, CMS is not liable for the reward payment and the suggester must refund all monies received.

(e) Requirements for submitting suggestions—(1) To be considered, the suggestion must be in writing, mailed to CMS, and must include the following information:

(i) A description of an existing problem or need;

(ii) A suggested method for solving the problem or filling the need; and

(iii) If known, an estimate of the savings potential that could result from implementing the suggestion.

(2) Suggestions must be mailed to: Centers for Medicare & Medicaid Services Suggestion Program, 7500 Security Blvd., Baltimore, Maryland 21244–1850.

(3) Any suggesters interested in receiving a reward must provide CMS with the following information: An individual suggester must provide his or her name, a group of suggesters must provide the names of all the group members, and a legal entity must provide its name and the name of its representative. All suggesters must provide an address, telephone number, and any other identifying information that CMS needs to contact the suggester for additional information and, where applicable, to mail the reward.

(f) Evaluation process—(1) Relevant factors. CMS evaluates all suggestions on the basis of the following factors:

(i) Originality of suggestion.

(ii) An estimate of potential monetary savings to the Medicare program.

(iii) The extent to which Medicare program efficiency would be improved if CMS adopts the suggestion.

(iv) Accuracy of the information reflected in the suggestion.

(v) Feasibility of implementation.

(vi) Nature and complexity of the suggestion.

and the awardee must refund all monies received.
(vii) Any other factors that appear to be relevant.

(2) Evaluation time limit. CMS concludes the evaluation process in a reasonable amount of time, not to exceed 2 years from the receipt date, taking into consideration the complexity of the suggestion, the number of possible implementation strategies, and CMS's current workload.

(g) Basis for reward payment—(1) General rule. If CMS determines that it is appropriate to make a reward payment for a suggestion adopted in whole or in part, that results in improved efficiency and monetary savings to the Medicare program, the payment is based on—

(i) The actual first-year net savings to the Medicare program, or

(ii) The average annual net savings to the Medicare program expected to be realized over a period of not more than 3 years if—

(A) An improvement is expected to yield monetary savings for more than 1 year and implementation involves substantial costs; or

(B) Monetary savings are negligible in the first year but are expected to substantially increase in subsequent years.

(2) Reward payment amount. CMS determines the amount of a reward payment using the following formula:

(i) Net savings from $1,000 to $10,000—10 percent of the savings, with a minimum award amount of $100;

(ii) Net savings of $10,001 to $100,000—$1,000 for the first $10,000 of savings, plus 3 percent of the net savings over $10,000;

(iii) Net savings of more than $100,000—$3,700 for the first $100,000 of savings, plus 0.5 percent of savings over $100,000, with a maximum award amount of $25,000.

(h) Adoption of suggestion and issuance of reward payment—(1) Adoption. Upon completing its evaluation, CMS decides whether to adopt a suggestion. If CMS receives the same or an overlapping suggestion from two or more unrelated parties, CMS will consider a reward only for the suggestion CMS received first, if the suggestion or overlapping part of the suggestion are identical, and CMS has adopted that part. If the suggestions are not identical, CMS will consider rewarding the suggestion received first, if it is feasible and CMS is able to adopt and implement the suggestion. If the first suggestion cannot be implemented, CMS may consider rewarding the suggestion received next, even if it is similar, provided CMS can adopt and implement the suggestion.

(2) Issuance of reward payment. After the reward payment amount is determined, as described in paragraph (g) of this section, CMS mails payment to the suggester (or to the legal representatives referenced in paragraph (k) of this section) only after the suggestion has been in operation for 1 year.

(i) Group suggestions. When CMS deems that a reward payment is appropriate for a suggestion submitted by a group of individuals, CMS pays an equal share of the reward to each of the individuals identified in the group. If an organization such as a corporation, partnership, or professional association submits a suggestion, CMS makes a single reward payment to that organization.

(j) Change in name or address. It is the suggester's responsibility to notify CMS of any change of address or other relevant information. If the suggester fails to update CMS on any change in this information, and the reward payment mailed to the suggester is returned to CMS, the suggester must claim the reward payment by contacting CMS within 1 year from the date CMS first mailed the reward payment to the suggester. CMS does not pay interest on rewards that, for any reason, are delayed or are not immediately claimed.

(k) Incapacitated or deceased suggester. If the suggester is incapacitated or has died, an executor, administrator, or other legal representative may claim the reward on behalf of the suggester or the suggester's estate. The claimant must submit certified copies of the letters testamentary, letters of administration, or other similar evidence to CMS showing his or her authority to claim the reward. The claim must be filed within 1 year from the date on which CMS first attempted to pay the reward to the individual who submitted the suggestion.
(1) Maintenance of records—(1) CMS retains records related to the administration of the suggestion program in accordance with 36 CFR part 1228 (the regulations for the National Archives and Records Administration).
(2) CMS does not disclose information submitted under the suggestion program, except as required by law.

[64 FR 66401, Nov. 26, 1999]

PART 421—MEDICARE CONTRACTING

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