

(a), (b), (c), and (i) are applicable to manufacturers, importers, and processors of this substance.

(2) *Limitations or revocation of certain notification requirements.* The provisions of § 721.185 apply to this significant new use rule.

28. By adding new § 721.9495 to subpart E to read as follows:

§ 721.9495 Acrylosilane resins.

(a) *Chemical substance and significant new uses subject to reporting.*

(1) The chemical substances identified as acrylosilane resins (PMNs P-95-1024/1040) are subject to reporting under this section for the significant new uses described in paragraph (a)(2) of this section.

(2) The significant new uses are:

(i) *Industrial, commercial and consumer activities.* Requirements as specified in § 721.80(l).

(ii) [Reserved]

(b) *Specific requirements.* The provisions of subpart A of this part apply to this section except as modified by this paragraph.

(1) *Recordkeeping.* Recordkeeping requirements as specified in § 721.125(a), (b), (c), and (i) are applicable to manufacturers, importers, and processors of this substance.

(2) *Limitations or revocation of certain notification requirements.* The provisions of § 721.185 apply to this section.

29. By adding new § 721.9507 to subpart E to read as follows:

§ 721.9507 Polyester silane.

(a) *Chemical substance and significant new uses subject to reporting.*

(1) The chemical substance identified as a polyester silane (P-95-1022) is subject to reporting under this section for the significant new uses described in paragraph (a)(2) of this section.

(2) The significant new uses are:

(i) *Industrial, commercial and consumer activities.* Requirements as specified in § 721.80(l).

(ii) [Reserved]

(b) *Specific requirements.* The provisions of subpart A of this part apply to this section except as modified by this paragraph.

(1) *Recordkeeping.* Recordkeeping requirements as specified in § 721.125(a), (b), (c), and (i) are applicable to manufacturers, importers, and processors of this substance.

(2) *Limitations or revocation of certain notification requirements.* The provisions of § 721.185 apply to this section.

30. By adding new § 721.9680 to subpart E to read as follows:

§ 721.9680 Alkaline titania silica gel (generic name).

(a) *Chemical substance and significant new uses subject to reporting.*

(1) The chemical substance identified generically as an alkaline titania silica gel (PMN P-95-529) is subject to reporting under this section for the significant new uses described in paragraph (a)(2) of this section.

(2) The significant new uses are:

(i) *Industrial, commercial, and consumer activities.* Requirements as specified in § 721.80 (v)(1), (w)(1), and (x)(1).

(ii) [Reserved]

(b) *Specific requirements.* The provisions of subpart A of this part apply to this section except as modified by this paragraph.

(1) *Recordkeeping.* Recordkeeping requirements as specified in § 721.125(a), (b), (c), and (i) are applicable to manufacturers, importers, and processors of these substances.

(2) *Limitations or revocation of certain notification requirements.* The provisions of § 721.185 apply to this significant new use rule.

31. By adding new § 721.9970 to subpart E to read as follows:

§ 721.9970 o-Xylene compound (generic name).

(a) *Chemical substance and significant new uses subject to reporting.*

(1) The chemical substance identified generically as an o-xylene compound (PMN P-95-1030) is subject to reporting under this section for the significant new uses described in paragraph (a)(2) of this section.

(2) The significant new uses are:

(i) *Industrial, commercial, and consumer activities.* Requirements as specified in § 721.80(j).

(ii) [Reserved]

(b) *Specific requirements.* The provisions of subpart A of this part apply to this section except as modified by this paragraph.

(1) *Recordkeeping.* Recordkeeping requirements as specified in § 721.125(a), (b), (c), and (i) are applicable to manufacturers, importers, and processors of this substance.

(2) *Limitations or revocation of certain notification requirements.* The provisions of § 721.185 apply to this section.

[FR Doc. 96-30474 Filed 11-29-96; 8:45 am]

BILLING CODE 6560-50-F

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 401, 403, 405, 411, 413, 447, and 493

[BPO-118-FC]

RIN 0938-AC99

Medicare Program; Changes Concerning Suspension of Medicare Payments, and Determinations of Allowable Interest Expenses

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

ACTION: Final rule with comment period.

SUMMARY: We are revising the Medicare regulations concerning suspension of Medicare payments and determination of allowable interest expenses. These changes are being made to conform the regulations with law and established policy, to provide necessary clarification, and to protect the Government's interests.

DATES: *Effective date:* These regulations are effective January 2, 1997.

Comment Date: We are providing a comment period on the issues described in section V of this preamble. Written comments will be considered if we receive them at the appropriate address, as provided below, no later than 5 p.m. on January 31, 1997.

ADDRESSES: Mail written comments (an original and three copies) to the following address: Health Care Financing Administration, Department of Health and Human Services, Attention: BPO-118-FC, P.O. Box 26688, Baltimore, MD 21207.

If you prefer, you may deliver your written comments (an original and three copies) to one of the following addresses:

Room 309-G, Hubert H. Humphrey Building, 200 Independence Avenue SW., Washington, DC 20201, or Room C5-09-26, 7500 Security Boulevard, Baltimore, MD 21244-1850.

Because of staffing and resource limitations, we cannot accept comments by facsimile (Fax) transmission. In commenting, please refer to file code BPO-118-FC. Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, in Room 309-G of the Department's offices at 200 Independence Ave., SW., Washington, DC, on Monday through Friday of each week from 8:30 a.m. to 5 p.m. (phone: (202) 690-7890).

FOR FURTHER INFORMATION CONTACT:

James Conrad (suspension of payments, fraud and abuse), (410) 786-6976; Ward Pleines (all other provisions), (410) 786-4528.

SUPPLEMENTARY INFORMATION:**I. Suspension of Medicare Payments****A. Background**

Sections 1815 (a) and (d) and 1833(j) of the Social Security Act (the Act) and the Federal Claims Collection Act of 1966, as amended, (31 U.S.C. 3711) allow a Medicare contractor (that is, an intermediary or carrier) that has the opportunity to offset an overpayment to do so. This provision is set forth in existing regulations at 42 CFR 401.607 (a) and (d) and 405.1803(c). In addition, existing § 405.370 provides that payments authorized to be made to providers and suppliers under the Medicare program may be suspended, in whole or in part, by a Medicare contractor when the contractor has determined that the provider or supplier has been overpaid or when the contractor has reliable evidence that either an overpayment exists or that the payments to be made may not be correct. Existing § 405.370(b), however, requires that, in order to proceed with a suspension of payment, the contractor must have determined that "the suspension of payments, in whole or in part, is needed to protect the program against financial loss." Section 405.370 does not specify the disposition of suspended payments, nor do the regulations address how long payment may be suspended. Also, the existing regulations do not differentiate between the terms "suspension of payments," "offset," and "recoupment."

In addition, the existing regulations do not clearly specify the procedures applicable when fraud is suspected; they merely provide that payment may be suspended without advance notice and that the provider or supplier will be notified of the suspension and the reasons for it. (When the existing regulations were published (May 27, 1972, 37 FR 10723), the HHS Office of Inspector General (OIG), which is responsible for conducting investigations involving fraud and willful misrepresentation, had not been created, and the Social Security Administration (SSA) administered the Medicare program. Suspension of Medicare payment based on fraud or abuse was accomplished by Medicare contractors in consultation with SSA, at the direction of the Bureau of Health Insurance, the SSA component then responsible for Medicare. Therefore, the

regulations reflect only the role of intermediaries and carriers.)

Under current law and delegations of authority, HCFA is responsible for operating the Medicare program. The OIG is responsible for conducting investigations and identifying wrongdoers and abusers of HHS programs so appropriate remedies can be applied, as well as identifying weaknesses or problems in the management of HHS programs. (See the Statements of Organization, Function, and Delegations of Authority, for HCFA and for OIG (49 FR 35247, published September 6, 1984, and 54 FR 46775, published November 7, 1989, respectively).)

B. Provisions of Proposed Rule

On August 22, 1988, we published a proposed rule, at 53 FR 31888, in which we proposed to eliminate the requirement that, before suspension of payment, the contractor make a determination that suspension of payments to a provider or supplier is needed to protect the program against financial loss. We also proposed clarifying our policy regarding the disposition of suspended payments. As proposed, suspended funds would first be applied to liquidate, in whole or in part, overpayments that are the basis for the suspension. Any remaining suspended funds would be applied to any other determined Medicare overpayments. In the absence of a further obligation to HHS (such as Medicaid overpayments) or other legal requirement (such as civil money penalties or an Internal Revenue Service levy), the excess would be released to the provider or supplier. Readers who are interested in the details of our proposals are referred to the proposed rule.

(Note that, in order to expedite certain changes that were contained in the August 1988 proposed rule, that is, proposed changes pertaining to the assessment of interest charges on overpayments and underpayments, we proceeded with them in a separate final rule, published in the Federal Register on July 10, 1991, at 56 FR 31332. The provisions of the July 1991 rule appear at § 405.376. The remaining proposed changes are contained in this final rule.)

C. Summary of and Responses to Public Comments

In response to the proposed rule, we received 12 items of correspondence, each containing comments on the issue of suspension of Medicare payments. The commenters included health care facilities, health care associations, a Medicare contractor, and an accounting

firm. Three commenters believed that the changes would make suspension more effective, would reduce administrative costs, and would have little effect on current practice. The other commenters were primarily concerned with the cash flow problems that could result from the suspension of payment without a 30-day notice. Their specific concerns are presented below. Note that, unless otherwise indicated, references in our responses to sections of the regulations are to the sections in this final rule.

Comment: Several commenters expressed concern that the proposed changes concerning suspension of Medicare payments in cases of overpayments would allow an intermediary or carrier to withhold all payment to a provider or supplier without notification until an overpayment was recouped and that this could have a devastating effect on the cash flow of providers and suppliers, possibly even causing bankruptcies.

Response: There appears to be some confusion and misunderstanding of the scope of the changes we proposed to make in this area. We generally do not intend to suspend payments without at least a 15-day notice of this action to the provider or supplier. (There are three exceptions to giving prior notice: (1) When a suspension is imposed in accordance with section 1815(a) or section 1833(e) of the Act because the provider or supplier, respectively, has failed to submit information requested by the Medicare contractor that is needed to determine the amounts due the provider or supplier; (2) when we or the Medicare contractor determines that the Medicare Trust funds would be harmed by giving prior notice; and (3) at our discretion in cases involving fraud or misrepresentation.) Our proposal merely intended to eliminate the requirement for a separate determination that a suspension of payments is necessary to protect Medicare against financial loss before contractors can proceed with the suspension. In addition, in this final rule, we clarify that at least a 15-day notice to the provider or supplier is given in cases of recoupment or offset, terms that are defined in this rule.

Payment is recouped or offset in those cases in which the amount of an overpayment has been determined, and any future payment to a provider or supplier will be offset (that is, applied) against the identified overpayment generally until the amount of the overpayment is recovered. Offset or recoupment constitutes constructive payment to the provider or supplier. Payment is suspended if we or the

Medicare contractor has determined that the provider or supplier has been overpaid but the actual amount of the overpayment has not yet been determined. Therefore, additional effort is required before the amount of the overpayment can be determined. We believe that the notice requirement provides ample time for providers and suppliers to submit evidence to the intermediary or carrier to prevent suspension, recoupment, or offset and to avoid cash flow problems. However, in response to the commenters' concerns and in an effort to eliminate confusion, in this final rule we have—

- Added, at § 405.370, the following definitions of “suspension of payment,” “offset,” and “recoupment.”

Offset. The recovery by Medicare of a non-Medicare debt by reducing present or future Medicare payments and applying the amount withheld to the indebtedness. (Examples are Public Health Service debts or Medicaid debts recovered by HCFA).

Recoupment. The recovery by Medicare of any outstanding Medicare debt by reducing present or future Medicare payments and applying the amount withheld to the indebtedness.

Suspension of payment. The withholding of payment by an intermediary or carrier from a provider or supplier of an approved Medicare payment amount before a determination of the amount of the overpayment exists.

- Reorganized and revised the provisions related to suspension of payment in order to set forth our policy more clearly (see § 405.372, “Proceeding for suspension of payment”). These changes from the proposed rule have been made to improve the readability of the regulations and to clearly set forth the existing process and policy; we have not made any substantive changes that were not included in our proposed rule or that are not being made in response to public comment. (Note that, because of the restructuring of the provisions related to suspension, it was necessary to also reorganize and revise other provisions set forth in existing §§ 405.370 through 405.373. Again, in accomplishing this reorganization, we have not made any substantive changes that were not included in our proposed rule or that are not being made in response to public comment.) We will, however, consider timely comments from anyone who believes that, in making these changes, we have unintentionally altered the meaning.

- Revised existing § 405.374, “Collection and compromise of claims for overpayment” by changing the section heading to “Suspension and

termination of collection action and compromise of claims for overpayment” to better describe the section’s contents (and redesignated it as § 405.376). For the same reason, we have revised the headings of paragraph (e) (from “Basis for terminations” to “Basis for termination of collection action”) and paragraph (f) (from “Basis for suspension” to “Basis for suspension of collection action”).

- Revised existing § 405.375, “Withholding Medicare payments to recover Medicaid overpayments” (and redesignated it as § 405.377), to clarify our policy with regard to withholding Medicare payments to offset Medicaid overpayments.

We are also taking this opportunity to create two separate provisions to address two separate situations concerning failure to furnish information. Current regulations at § 405.371(d) (“Failure to furnish information requested”) provide for suspending payments in all situations in which information is not supplied, including when a provider fails to file a cost report. It has been our long-standing policy that, if a provider has failed to timely file an acceptable cost report, payment is immediately suspended until an acceptable cost report is filed. This regulation and policy are based on sections 1815(a) and 1833(e) of the Act. Section 1815(a) provides, in part, that “no * * * payments shall be made to any provider unless it has furnished such information as the Secretary may request in order to determine the amounts due such provider under this part [Medicare Part A] for the period with respect to which the amounts are being paid or any prior period.” Section 1833(e) of the Act contains similar language with respect to payments made under Part B of Medicare.

In this final rule we set forth a separate provision, new § 405.371(c), specifically addressing the suspension of payments in the case of unfiled cost reports. Section 405.371(c) specifies that, if a provider has failed to timely file an acceptable cost report, payment to the provider is immediately suspended until a cost report is filed and determined by the intermediary to be acceptable. This section further specifies that, in the case of an unfiled cost report, the provisions of § 405.372 (“Proceeding for suspension of payment”) do not apply. We believe that this is consistent with the above-cited mandate that “no payment shall be made * * * unless it has furnished such information * * *.”

In addition, we are retaining, with editorial modifications, the provision in

current regulations at § 405.371(d) to apply to all instances of failure to supply information except those in which a cost report is not filed. This provision is set forth at § 405.372(a)(2) in this final rule. As in the current regulations, it specifies that the prior notice and rebuttal provisions do not apply if the provider failed to submit evidence requested by the intermediary that is needed to determine the amounts due the provider under the Medicare program. However, unlike new § 405.371(c) (“Suspension in the case of unfiled cost reports”), the time limitation on suspension established by this final rule, and discussed in the response to the following comment, applies.

Comment: Since immediate suspension of payments could cause great hardship to many Medicare providers and suppliers, one commenter believed it only fair to continue the requirement of a separate determination that suspension is needed to protect the program from financial loss.

Response: As discussed above, all providers and suppliers will generally receive prior notification of the suspension, recoupment, or offset action and have at least 15 days to reply. The notification of overpayment will state that, if there is no reply within the timeframe specified in the notification, the Medicare contractor will then begin action. If no reply is received from the provider or supplier, we believe that suspension is required to protect a program such as Medicare or Medicaid from financial loss and that it is not necessary to make a separate determination on that fact. Even if a reply is received, suspension may be required, and a separate determination is unnecessary.

If the provider or supplier submits a statement as to why a suspension of payment, recoupment, or offset should not be put into effect, the intermediary or carrier will have 15 days from the date the statement is received to consider the statement and make a determination whether the facts justify a suspension, or removal of a suspension already initiated. Suspension, however, will not be delayed in order to review any statement submitted.

In further response to the concerns expressed by the commenters, we have decided to impose a limitation upon how long we will suspend payment pending a determination whether or not an overpayment exists and in matters involving fraud or willful misrepresentation. The purpose of suspending payment is to verify whether, and how much, payment was

actually due the provider for past claims and to ensure that, if a provider or supplier was overpaid, sufficient funds are available to recover the overpayment. These actions are clearly necessary to protect the Trust Funds from loss. It is implicit that, when payment is suspended, determinations of overpayment, or of fraud or willful misrepresentation, should be made promptly. Accordingly, because it is appropriate that a provider or supplier receive a prompt determination so that it may receive any balances actually due after application of recoupment or offset, we have decided to limit suspension of Medicare payment to 180 days, with a possible extension of up to 180 additional days being granted to the intermediary, carrier, or OIG by HCFA. This period will enable us or the carrier or intermediary, as the case may be, to investigate and to determine the amounts of any Medicare overpayments or, in cases involving the OIG, for the OIG to complete its investigation, while protecting the Medicare Trust Funds. At the same time, providers and suppliers have the security of knowing that the suspension may culminate in an appealable determination within a specific period of time if the claims are subsequently denied. (A decision to suspend payment is not an initial determination subject to appeal under §§ 405.704, 405.803, or 405.1803.)

In addition, we recognize that there may be special circumstances in which the specified time limit (that is, 180 days plus up to 180 additional days) may not be sufficient. Therefore, we may grant an exception to the time limits in the following situations:

- The case has been referred to, and is being considered by, the OIG for administrative action, that is, civil money penalties.
- The Department of Justice, generally through the United States Attorney with jurisdictional responsibility, submits a written request to HCFA that the suspension be continued based on the ongoing investigation and anticipated filing of criminal and/or civil actions. At a minimum, the request must include the following:

*Identification of the entity under suspension.

*The amount of time needed for continued suspension in order to implement the criminal and/or civil proceedings.

*A statement of why and/or how criminal and/or civil actions may be affected if the requested extension is not granted.

Once a determination is made, any overpayments will be recouped or

offset, first from suspended funds, then from any other monies owed the debtor in accordance with usual Medicare program rules. (See, for example, § 401.607(a)). Note that, in contrast to the decision to suspend payment, an overpayment determination is an initial determination, subject to appeal, but that appeals do not delay recoupment. Also note that, as defined in this final rule at § 405.370, recoupment may constitute 100 percent of any monies due if the debt to Medicare is equal to or greater than the amounts payable. Nonetheless, for the very reasons raised by the commenters, Medicare usually does not impose 100 percent recoupment in the absence of a basis for doing so, such as the debtor's failure to respond to a demand letter.

Under current law and delegations of authority, HCFA is responsible for operating the Medicare program. This includes making determinations whether to suspend payment. In cases of suspected fraud or willful misrepresentation, the determination whether to suspend is generally made after consultation with the OIG, the Medicare contractor, U.S. Attorney, and other law enforcement agencies as appropriate to the case. Where the OIG or other law enforcement agency requests suspension, the requesting agency must advise us of the basis for the request. Thus, although the OIG is responsible for identifying, investigating, and pursuing matters of fraud and abuse, HCFA is responsible for determining whether there is reliable evidence of an overpayment, whether to suspend payment, and, if the decision is to suspend payment, whether advance notice of the suspension should be given. (If advance notice is to be given, we usually direct the Medicare contractor to give the notice.) The Medicare contractor is responsible for promptly determining the overpayment. Once the amount of an overpayment is determined, the suspended payments are applied to recoup the overpayment. Although the Medicare contractor may implement a suspension, offset, or recoupment, HCFA is the real party in interest and is responsible for the actions.

This final rule clarifies that our decision regarding whether to suspend payment may be based on information provided by the intermediary, carrier, a law enforcement agency, or other source. We will normally provide at least a 15-day delay before suspension is imposed. However, when it appears that the Medicare Trust Funds would be harmed by providing this notice or in matters involving fraud or misrepresentation, suspension may be

imposed without prior notice. (We believe, however, that suspension without prior notice would be the exception.)

II. Determination of Allowable Interest Expense

A. Background

Under the Medicare program, health care providers not subject to the prospective payment system generally are paid for the reasonable costs of the covered items and services they furnish to Medicare beneficiaries. Section 1861(v)(1)(A) of the Act defines reasonable costs as the cost actually incurred, excluding any cost unnecessary in the efficient delivery of needed health services. Section 1861(v)(1)(A) also provides that reasonable costs be determined in accordance with regulations that establish the methods to be used and the items to be included for purposes of determining which costs are allowable for various types or classes of institutions, agencies, and services.

Providers may generally include interest expense (the cost incurred for the use of funds borrowed for patient care-related purposes) in allowable costs, but, under existing § 413.153(b)(2)(iii), allowable interest expense must be reduced by investment income. Additionally, this section of the regulations provides that investment income from gifts and grants (whether restricted or unrestricted) is not used to reduce interest expense if the gift and grant funds are held separate and not commingled with other funds. The latter provision was intended to ensure that providers maintain the discrete nature of the grant funds and to facilitate the intermediaries' application of proper payment principles to the resulting investment income.

Section 1134 of the Act, which was added by section 901 of the Omnibus Reconciliation Act of 1980 (ORA '80), Public Law 96-499, provides that, in the case of nonprofit hospitals, interest income from grants, gifts, or endowments, that have not been designated by the donor to be used to defray specific operating costs, is not to be offset against interest income.

The provisions of section 901 of ORA '80, as well as our established position on commingling of funds, were incorporated in Transmittal No. 279 issued in January 1983. This transmittal, which revised section 202.6 of the Provider Reimbursement Manual (HCFA Pub. 15-1), permits the pooling of funds for investment purposes, provided adequate records are maintained to enable the proper identification of funds

and investment income applicable to each.

Existing § 413.153(b)(2)(iii) excludes the following types of income from the interest expense offset requirements:

- Investment income from separately held and noncommingled gifts and grants.
- Income from a provider's funded depreciation.
- Income from qualified employee pension funds.
- Interest received as a result of judicial review by a Federal court.

Under our current operating policy, investment income from a provider's deferred compensation funds and self-insurance funds that meet the program's qualifying compensation plans provided in section 2140 of the Provider Reimbursement Manual and the qualifying criteria for self-insurance funds described in subsection 2162.7 of the Manual must become part of those funds and, as such, is unavailable for offset against interest expense.

B. Provisions of the Proposed Regulations

We proposed to revise § 413.153(b)(2)(iii) to modify the restriction against commingling to permit the pooling of grant, gift, or endowment funds for investment purposes for all providers, rather than only the nonprofit hospitals referenced in section 1134 of the Act. This change was proposed to conform the regulations to our current operating policy as set forth in section 202.6 of the Provider Reimbursement Manual (HCFA Pub. 15-1).

As a conforming change, we also proposed to remove the regulations text located at § 413.5(c)(3). This section contains outdated statements concerning offsetting of restricted grants, gifts, and income from endowments and ceased being effective with cost reporting periods beginning on or after October 1, 1983.

We also proposed to make a technical change to the regulations at § 413.90(b)(2) to remove the provision that required the offset of research grant funds (used for usual patient care purposes in conjunction with basic medical and hospital research) against usual patient care costs. This provision became obsolete with cost reporting periods beginning on or after October 1, 1983.

We further proposed to clarify § 413.153(b)(2)(iii) by adding to the exclusions from interest expense offset investment income on—

- A provider's deferred compensation plans; and
- Self-insurance trust funds.

Because established program policy has always required that investment income earned on a provider's deferred compensation fund (Provider Reimbursement Manual, section 2140 ff.) or self-insurance fund (section 2162.7) become part of those funds, it is unavailable for offset against interest expense. We simply proposed to add these exclusions from interest expense offset to the regulations text to conform it to the established policy.

C. Analyses of and Responses to Public Comments

We received a comment on these proposals with the following concern:

Comment: The commenter requested that the proposed clarification of § 413.153(b)(2)(iii) to permit the pooling of funds from grants and gifts be further modified to explicitly include monies from funded depreciation for nonprofit hospitals.

Response: Section 413.153(b)(2)(iii) never prohibited the commingling of funded depreciation monies for investment purposes by either proprietary or nonprofit providers. Therefore, we believe that the change suggested by the commenter is unnecessary.

III. Provisions of the Final Rule

This final rule with comment period incorporates those provisions of the August 1988 proposed rule that were not incorporated into the regulations by the July 10, 1991 final rule, with the changes listed below. The rationale for these changes has been discussed above in our responses to comments.

- We include definitions of the terms "offset," "recoupment," and "suspension of payment." (See § 405.370.)

- We clarify that at least a 15-day notice to the provider or supplier is given in cases of recoupment or offset, as well as in cases of suspension of payment. (See § 405.374(a).)

- We limit the duration of a suspension of payment. (See § 405.372(d).)

- We clarify the procedures applicable to suspension of payment when fraud or willful misrepresentation is suspected. (See § 405.372 (a) and (e).)

In addition to the above changes, which were discussed in the responses to comments, we make the following clarifying, conforming, and technical changes:

- We revise § 401.601, which sets forth the basis and scope of subpart F (Claims Collection and Compromise) of part 401 (General Administrative Requirements). Paragraph (d) of this section identifies, as related regulations,

HHS regulations applicable to HCFA that generally implement the Federal Claims Collection Act (FCCA) for the Department and are located at 45 CFR part 30. We add a statement to paragraph (d) to clarify that those regulations apply only to the extent HCFA regulations do not address a situation.

- We revise § 401.607 (Claims collection). Paragraph (d)(1) of this section states that "[i]n conformity with 4 CFR 102.3, HCFA may offset, where possible, the amount of a claim against the amount of * * * monies that a debtor is receiving or is due from the Federal government." The "conformity" phrase was included to reflect that offset of Medicare debts is consistent with general FCCA regulations. It was not intended to impose additional requirements not included in HCFA's FCCA regulations. It has come to our attention, however, that this phrase has caused confusion. Therefore, in order to eliminate this confusion, we remove the phrase.

- In § 405.1803, "Intermediary determination and notice of amount of program reimbursement," we revise paragraph (c), currently titled "Use of notice as basis for recovery of overpayments," to conform it to the terminology and process this rule establishes in §§ 405.370 through 405.377. First, we change the word "recovery" wherever it appears in paragraph (c) to "recoupment". Second, we replace the phrase "including the suspending of further payments to the provider in order to recover, or to aid in the recovery of," with "including recoupment under § 405.373 from ongoing payment to the provider of". Third, we make a minor editorial change to break the existing first sentence into two sentences. Finally, because the cross reference made by the last sentence is no longer correct and we believe a cross reference is not necessary, we remove the last sentence.

- We make a number of technical changes (such as revising cross-reference citations because of the redesignations made by this final rule) that do not affect the substance of the provisions.

IV. 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 final rule with comment period will not have a significant economic impact on a substantial number of small entities. For purposes of the RFA, all providers and suppliers are considered to be small entities.

In addition, section 1102(b) of the Act requires the Secretary 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 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.

Elimination of the requirement at existing § 405.370(b) that an intermediary or carrier make a prior determination that a suspension of payment is needed to protect the Medicare program against financial loss may have an adverse economic effect on some providers and suppliers. However, we do not believe that this policy will affect a significant number of providers and suppliers. Additionally, the time limits on suspension established by this final rule may mitigate the adverse effect of our modifications to § 405.370(b).

In addition to the changes previously discussed in the notice of proposed rulemaking, we have made certain clarifying changes. We do not anticipate any economic effects resulting from our clarifications of already existing policy.

For these reasons, we are not preparing analyses for either the RFA or section 1102 of the Act since we have determined, and the Secretary certifies, that this rule will not result in a significant economic impact on a substantial number of small entities and will not have a significant impact on the operations of a substantial number of small rural hospitals.

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

V. Public Comment Period

We have made certain changes from the proposed rule to improve the readability of the regulations and to clearly set forth the existing process and policy. In doing so, we have not made any substantive changes to existing regulations that were not included in our proposed rule or that are not being made in response to public comment on the proposed rule. While a prior public comment period is not required in this case, we are granting the public an opportunity to comment on these changes. As stated earlier, we are providing 60-day comment period on the following:

(1) The differences between suspension, recoupment, and offset.

(2) The fact that suspension or offset or recoupment will not be delayed beyond the date stated in the notice from the intermediary or carrier in order to review any statement submitted.

(3) The inclusion of time limits on the period during which payment may be suspended.

(4) The clarification of applicable procedures in the case of suspension of payment if fraud or willful misrepresentation is suspected.

(5) The creation of two separate provisions concerning suspension of payment for failure to furnish information.

(6) The reorganization of the provisions.

Because of the large number of items of correspondence we normally receive on regulations, we cannot acknowledge or respond to them individually. We will, however, consider all comments concerning the issues noted directly above that are received by the date and time specified in the "DATES" section of this preamble. If we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

List of Subjects

42 CFR Part 401

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

42 CFR Part 403

Health insurance, Hospitals, Intergovernmental relations, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 405

Administrative practice and procedure, Health facilities, Health professions, Kidney diseases, Medicare, Reporting and recordkeeping requirements, Rural areas, X-rays.

42 CFR Part 411

Kidney diseases, Medicare, Physician referral, Reporting and recordkeeping requirements.

42 CFR Part 413

Health facilities, Kidney diseases, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

42 CFR Part 447

Accounting, Administrative practice and procedure, Drugs, Grant programs—health, Health facilities, Health professions, Medicaid, Reporting and recordkeeping requirements, Rural areas.

42 CFR Part 493

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

42 CFR chapter IV is amended as follows:

PART 405—FEDERAL HEALTH INSURANCE FOR THE AGED AND DISABLED

A. Part 405 is amended as set forth below:

Subpart C—Suspension of Payment, Recovery of Overpayments, and Repayment of Scholarships and Loans

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

Authority: Secs. 1102, 1815, 1833, 1842, 1866, 1870, 1871, 1879 and 1892 of the Social Security Act (42 U.S.C. 1302, 1395g, 1395l, 1395u, 1395cc, 1395gg, 1395hh, 1395pp and 1395ccc) and 31 U.S.C. 3711.

2. The undesignated center heading preceding § 405.370 is revised to read as follows:

SUSPENSION AND RECOUPMENT OF PAYMENT TO PROVIDERS AND SUPPLIERS AND COLLECTION AND COMPROMISE OF OVERPAYMENTS

3. Sections 405.370 through 405.373 are redesignated as §§ 405.371 through 405.374, respectively, and current §§ 405.374 through 405.376 are redesignated as § 405.376 through 405.378, respectively.

4. New §§ 405.370 and 405.375 are added, and redesignated §§ 405.371 through 405.374 are revised, to read as follows:

§ 405.370 Definitions.

For purposes of this subpart, the following definitions apply:

Offset. The recovery by Medicare of a non-Medicare debt by reducing present or future Medicare payments and applying the amount withheld to the indebtedness. (Examples are Public Health Service debts or Medicaid debts recovered by HCFA).

Recoupment. The recovery by Medicare of any outstanding Medicare debt by reducing present or future Medicare payments and applying the amount withheld to the indebtedness.

Suspension of payment. The withholding of payment by an intermediary or carrier from a provider or supplier of an approved Medicare payment amount before a determination of the amount of the overpayment exists.

§ 405.371 Suspension, offset, and recoupment of Medicare payments to providers and suppliers of services.

(a) *General.* Medicare payments to providers and suppliers, as authorized under this subchapter (excluding payments to beneficiaries), may be—

(1) Suspended, in whole or in part, by HCFA, an intermediary, or a carrier if HCFA, the intermediary, or the carrier possesses reliable information that an overpayment or fraud or willful misrepresentation exists or that the payments to be made may not be correct, although additional evidence may be needed for a determination; or

(2) Offset or recouped, in whole or in part, by an intermediary or a carrier if the intermediary, carrier, or HCFA has determined that the provider or supplier to whom payments are to be made has been overpaid.

(b) Steps necessary for suspension of payment, offset, and recoupment.

Except as provided in paragraph (c) of this section, HCFA, the intermediary, or carrier suspends payments only after it has complied with the procedural requirements set forth at § 405.372. The intermediary or carrier offsets or recoups payments only after it has complied with the procedural requirements set forth at § 405.373.

(c) Suspension of payment in the case of unfiled cost reports. If a provider has failed to timely file an acceptable cost report, payment to the provider is immediately suspended until a cost report is filed and determined by the intermediary to be acceptable. In the case of an unfiled cost report, the provisions of § 405.372 do not apply. (See § 405.372(a)(2) concerning failure to furnish other information.)

§ 405.372 Proceeding for suspension of payment.

(a) *Notice of intention to suspend—(1) General rule.* Except as provided in paragraphs (a)(2) through (a)(4) of this section, if the intermediary, carrier, or HCFA has determined that a suspension of payments under § 405.371(a)(1) should be put into effect, the intermediary or carrier must notify the provider or supplier of the intention to suspend payments, in whole or in part, and the reasons for making the suspension.

(2) *Failure to furnish information.* The notice requirement of paragraph (a)(1) of this section does not apply if the intermediary or carrier suspends payments to a provider or supplier in accordance with section 1815(a) or section 1833(e) of the Act, respectively, because the provider or supplier has failed to submit information requested by the intermediary or carrier that is

needed to determine the amounts due the provider or supplier. (See § 405.371(c) concerning failure to file timely acceptable cost reports.)

(3) *Harm to Trust Funds.* A suspension of payment may be imposed without prior notice if HCFA, the intermediary, or carrier determines that the Medicare Trust Funds would be harmed by giving prior notice. HCFA may base its determination on an intermediary's or carrier's belief that giving prior notice would hinder the possibility of recovering the money.

(4) *Fraud or misrepresentation.* If the intended suspension of payment involves suspected fraud or misrepresentation, HCFA determines whether to impose the suspension and if prior notice is appropriate. HCFA directs the intermediary or carrier as to the timing and content of the notification to the provider or supplier. HCFA is the real party in interest and is responsible for the decision. HCFA may base its decision on information from the intermediary, carrier, law enforcement agencies, or other sources. HCFA determines whether the information is reliable.

(b) Rebuttal—(1) If prior notice is required. If prior notice is required under paragraph (a) of this section, the intermediary or carrier must give the provider or supplier an opportunity for rebuttal in accordance with § 405.374. If a rebuttal statement is received within the specified time period, the suspension of payment goes into effect on the date stated in the notice, and the procedures and provisions set forth in § 405.375 apply. If by the end of the period specified in the notice no statement has been received, the suspension goes into effect automatically, and the procedures set forth in paragraph (c) of this section are followed.

(2) *If prior notice is not required.* If, under the provisions of paragraphs (a)(2) through (a)(4) of this section, a suspension of payment is put into effect without prior notice to the provider or supplier, the intermediary or carrier must, once the suspension is in effect, give the provider or supplier an opportunity to submit a rebuttal statement as to why the suspension should be removed.

(c) *Subsequent action.* If a suspension of payment is put into effect, the intermediary, carrier, or HCFA takes timely action after the suspension to obtain the additional evidence it may need to make a determination as to whether an overpayment exists or the payments may be made. The intermediary, carrier, or HCFA makes all reasonable efforts to expedite the

determination. As soon as the determination is made, the intermediary or carrier informs the provider or supplier and, if appropriate, the suspension is rescinded or any existing recoupment or offset is adjusted to take into account the determination.

(d) Duration of suspension of payment—(1) General rule. Except as provided in paragraphs (d)(2) and (d)(3) of this section, a suspension of payment is limited to 180 days, starting with the date the suspension begins.

(2) *180-day extension.* (i) An intermediary, a carrier, or, in cases of fraud and misrepresentation, OIG or a law enforcement agency, may request a one-time only extension of the suspension period for up to 180 additional days if it is unable to complete its examination of the information or investigation, as appropriate, within the 180-day time limit. The request must be submitted in writing to HCFA.

(ii) Upon receipt of a request for an extension, HCFA notifies the provider or supplier of the requested extension. HCFA then either extends the suspension of payment for up to an additional 180 days or determines that the suspended payments are to be released to the provider or supplier.

(3) *Exceptions to the time limits.* (i) The time limits specified in paragraphs (d)(1) and (d)(2) of this section do not apply if the case has been referred to, and is being considered by, the OIG for administrative action (for example, civil money penalties).

(ii) HCFA may grant an extension in addition to the extension provided under paragraph (d)(2) of this section if the Department of Justice submits a written request to HCFA that the suspension of payment be continued based on the ongoing investigation and anticipated filing of criminal and/or civil actions. At a minimum, the request must include the following:

(A) Identification of the entity under suspension.

(B) The amount of time needed for continued suspension in order to implement the criminal and/or civil proceedings.

(C) A statement of why and/or how criminal and/or civil actions may be affected if the requested extension is not granted.

(e) *Disposition of suspended payments.* Payments suspended under the authority of § 405.371(b) are first applied to reduce or eliminate any overpayments determined by the intermediary, carrier, or HCFA, including any interest assessed under the provisions of § 405.378, and then applied to reduce any other obligation

to HCFA or to HHS. In the absence of a legal requirement that the excess be paid to another entity, the excess is released to the provider or supplier.

§ 405.373 Proceeding for offset or recoupment.

(a) *General rule.* Except as specified in paragraph (b) of this section, if the intermediary, carrier, or HCFA has determined that an offset or recoupment of payments under § 405.371(a)(2) should be put into effect, the intermediary or carrier must—

(1) Notify the provider or supplier of its intention to offset or recoup payment, in whole or in part, and the reasons for making the offset or recoupment; and

(2) Give the provider or supplier an opportunity for rebuttal in accordance with § 405.374.

(b) Paragraph (a) of this section does not apply if the intermediary, after furnishing a provider a written notice of the amount of program reimbursement in accordance with § 405.1803, recoups payment under paragraph (c) of § 405.1803. (For provider rights in this circumstance, see §§ 405.1809, 405.1811, 405.1815, 405.1835, and 405.1843.)

(c) *Actions following receipt of rebuttal statement.* If a provider or supplier submits, in accordance with § 405.374, a statement as to why an offset or recoupment should not be put into effect on the date specified in the notice, the intermediary or carrier must comply with the time limits and notification requirements of § 405.375.

(d) *No rebuttal statement received.* If, by the end of the time period specified in the notice, no statement has been received, the recoupment or offset goes into effect automatically.

(e) *Duration of recoupment or offset.* If a recoupment or offset is put into effect, it remains in effect until the earliest of the following:

(1) The overpayment and any assessed interest are liquidated.

(2) The intermediary or carrier obtains a satisfactory agreement from the provider or supplier for liquidation of the overpayment.

(3) The intermediary or carrier, on the basis of subsequently acquired evidence or otherwise, determines that there is no overpayment.

§ 405.374 Opportunity for rebuttal.

(a) *General rule.* If prior notice of the suspension of payment, offset, or recoupment is given under § 405.372 or § 405.373, the intermediary or carrier must give the provider or supplier an opportunity, before the suspension, offset, or recoupment takes effect, to

submit any statement (to include any pertinent information) as to why it should not be put into effect on the date specified in the notice. Except as provided in paragraph (b) of this section, the provider or supplier has at least 15 days following the date of notification to submit the statement.

(b) *Exception.* The intermediary or carrier may for cause—

(1) Impose a shorter period for rebuttal; or

(2) Extend the time within which the statement must be submitted.

§ 405.375 Time limits for, and notification of, administrative determination after receipt of rebuttal statement.

(a) *Submission and disposition of evidence.* If the provider or supplier submits a statement, under § 405.374, as to why a suspension of payment, offset, or recoupment should not be put into effect, or, under § 405.372(b)(2), why a suspension should be terminated, HCFA, the intermediary, or carrier must within 15 days, from the date the statement is received, consider the statement (including any pertinent evidence submitted), together with any other material bearing upon the case, and determine whether the facts justify the suspension, offset, or recoupment or, if already initiated, justify the termination of the suspension, offset, or recoupment. Suspension, offset, or recoupment is not delayed beyond the date stated in the notice in order to review the statement.

(b) *Notification of determination.* The intermediary or carrier must send written notice of the determination made under paragraph (a) of this section to the provider or supplier. The notice must—

(1) In the case of offset or recoupment, contain rationale for the determination; and

(2) In the case of suspension of payment, contain specific findings on the conditions upon which the suspension is initiated, continued, or removed and an explanatory statement of the determination.

(c) *Determination is not appealable.* A determination made under paragraph (a) of this section is not an initial determination and is not appealable.

5. In redesignated § 405.376, the heading of the section, paragraph (a), and the headings of paragraphs (e) and (f) are revised to read as follows:

§ 405.376 Suspension and termination of collection action and compromise of claims for overpayment.

(a) *Basis and purpose.* This section contains requirements and procedures for the compromise of, or suspension or

termination of collection action on, claims for overpayments against a provider or a supplier under the Medicare program. It is adopted under the authority of the Federal Claims Collection Act (31 U.S.C. 3711). Collection and compromise of claims against Medicare beneficiaries are explained at 20 CFR 404.515.

* * * * *

(e) *Basis for termination of collection action.*

* * * * *

(f) *Basis for suspension of collection action.*

* * * * *

6. Redesignated § 405.377 is revised to read as follows:

§ 405.377 Withholding Medicare payments to recover Medicaid overpayments.

(a) *Basis and purpose.* This section implements section 1885 of the Act, which provides for withholding Medicare payments to certain Medicaid providers that have not arranged to repay Medicaid overpayments as determined by the Medicaid State agency or have failed to provide information necessary to determine the amount (if any) of overpayments.

(b) *When withholding may be used.* HCFA may withhold Medicare payment to offset Medicaid overpayments that a Medicaid agency has been unable to collect if—

(1) The Medicaid agency has followed the procedure specified in § 447.31 of this chapter; and

(2) The institution or person is one described in paragraph (c) of this section and either—

(i) Has not made arrangements satisfactory to the Medicaid agency to repay the overpayment; or

(ii) Has not provided information to the Medicaid agency necessary to enable the agency to determine the existence or amount of Medicaid overpayment.

(c) *Institutions or persons affected.* Withholding under paragraph (b) of this section may be made with respect to any of the following entities that has or had in effect an agreement with a Medicaid agency to furnish services under an approved Medicaid State plan:

(1) An institutional provider that has in effect an agreement under section 1866 of the Act. (Part 489 (Provider and Supplier Agreements) implements section 1866 of the Act.)

(2) A physician or supplier that has accepted payment on the basis of an assignment under section 1842(b)(3)(B)(ii) of the Act. (Section 424.55 sets forth the conditions a supplier agrees to in accepting assignment.)

(d) *Amount to be withheld.* (1) HCFA contacts the appropriate intermediary or carrier to determine the amount of Medicare payment to which the institution or person is entitled.

(2) HCFA may require the intermediary or carrier to withhold Medicare payments to the institution or person by the lesser of the following amounts:

(i) The amount of the Medicare payments to which the institution or person would otherwise be entitled.

(ii) The total Medicaid overpayment to the institution or person.

(e) *Notice of withholding.* If HCFA intends to withhold payments under this section, it notifies by certified mail, return receipt requested, the institution or person and the appropriate intermediary or carrier of the intention to withhold Medicare payments and follows the procedure in § 405.374. The notice includes—

(1) Identification of the institution or person; and

(2) The amount of Medicaid overpayment to be withheld from payments to which the institution or person would otherwise be entitled under Medicare.

(f) *Termination of withholding.* HCFA terminates the withholding if—

(1) The Medicaid overpayment is completely recovered;

(2) The institution or person enters into an agreement satisfactory to the Medicaid agency to repay the overpayment; or

(3) The Medicaid agency determines that there is no overpayment based on newly acquired evidence or a subsequent audit.

(g) *Disposition of funds withheld.* HCFA releases amounts withheld under this section to the Medicaid agency to be applied against the Medicaid overpayment made by the State agency.

Subpart R—Provider Reimbursement Determinations and Appeals

7. The authority citation for part 405, subpart R continues to read as follows:

Authority: Secs. 205, 1102, 1814(b), 1815(a), 1833, 1861(v), 1871, 1872, 1878, and 1886 of the Social Security Act (42 U.S.C. 405, 1302, 1395(b), 1395g(a), 1395i, 1395x(v), 1395hh, 1395ii, 1395oo, and 1395ww).

8. In § 405.1803, paragraph (c) is revised to read as follows:

§ 405.1803 Intermediary determination and notice of amount of program reimbursement.

* * * * *

(c) *Use of notice as basis for recoupment of overpayments.* The intermediary's determination contained

in its notice is the basis for making the retroactive adjustment (required by § 413.64(f) of this chapter) to any program payments made to the provider during the period to which the determination applies, including recoupment under § 405.373 from ongoing payments to the provider of any overpayments to the provider identified in the determination. Recoupment is made notwithstanding any request for hearing on the determination the provider may make under § 405.1811 or § 405.1835.

PART 413—PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END-STAGE RENAL DISEASE SERVICES; OPTIONAL PROSPECTIVELY DETERMINED PAYMENT RATES FOR SKILLED NURSING FACILITIES

B. Part 413 is amended as set forth below:

1. The authority citation for part 413 continues to read as follows:

Authority: Sec. 1102, 1861(v)(1)(A), and 1871 of the Social Security Act (42 U.S.C. 1302, 1395x(v)(1)(A), and 1395hh).

§ 413.5 [Amended]

2. In § 413.5, paragraph (c)(3) is removed and reserved.

3. In § 413.90, paragraph (b)(2) is revised to read as follows:

§ 413.90 Research costs.

* * * * *

(b) *Application.* (1) * * *

(2) If research is conducted in conjunction with, and as a part of, the care of patients, the costs of usual patient care and studies, analyses, surveys, and related activities to serve the provider's administrative and program needs are allowable costs in the determination of payment under Medicare.

4. In § 413.153, paragraph (a)(1) introductory text is republished, and paragraphs (a)(1)(ii) and (b)(2) are revised to read as follows:

§ 413.153 Interest expense.

(a)(1) *Principle.* Necessary and proper interest on both current and capital indebtedness is an allowable cost. However, interest costs are not allowable if incurred as a result of—

(i) * * *

(ii) An interest assessment on a determined overpayment (as described in § 405.377 of this chapter); or

* * * * *

(b) *Definitions.* (1) * * *

(2) *Necessary.* Necessary interest is interest that meets the following requirements:

(i) It is incurred on a loan made to satisfy a financial need of the provider. Loans that result in excess funds or investments are not considered necessary.

(ii) It is incurred on a loan made for a purpose reasonably related to patient care.

(iii) It is reduced by investment income except income from—

(A) Gifts, grants, and endowments, whether held separately or pooled with other funds;

(B) Funded depreciation that meets the program's qualifying criteria;

(C) The provider's qualified pension funds;

(D) The provider's deferred compensation funds that meet the program's qualifying criteria; and

(E) The provider's self-insurance trust funds that meet the program's qualifying criteria.

(iv) It is not reduced by interest received as a result of judicial review by a Federal court (as described in § 413.64(j)).

* * * * *

C. Technical Amendments.

PART 401—GENERAL ADMINISTRATIVE REQUIREMENTS

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

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

§ 401.601 [Amended]

2. In § 401.601, the following changes are made:

a. The following sentence is added at the end of paragraph (d)(1): "These regulations apply only to the extent HCFA regulations do not address a situation."

b. In paragraph (d)(2)(iii), the phrase "§§ 405.374 and 405.376" is removed, and the phrase "§§ 405.377 and 405.378" is added in its place.

§ 401.607 [Amended]

3. In § 401.607, in paragraph (d)(1), the phrase "In conformity with 4 CFR 102.3," is removed.

PART 403—SPECIAL PROGRAMS AND PROJECTS

4. The authority citation for part 403 continues to read as follows:

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

§ 403.310 [Amended]

5. In § 403.310, in the last sentence of paragraph (a), the citation "§ 405.376" is

removed, and the citation “§ 405.378” is added in its place.

PART 405—FEDERAL HEALTH INSURANCE FOR THE AGED AND DISABLED

Subpart G—Reconsiderations and Appeals Under Medicare Part A

6. The authority citation for part 405, subpart G continues to read as follows:

Authority: Secs. 1102, 1151, 1154, 1156, 1869(b), 1871, 1872, and 1879 of the Social Security Act (42 U.S.C. 1302, 1320c, 1320c-3, 1320c-4, 1395ff(b), 1395hh, 1395ii, and 1395pp).

§ 405.705 [Amended]

7. In § 405.705, in paragraph (d), the following changes are made:

a. The citation “(31 U.S.C. 951–953)” is removed, and the citation “(31 U.S.C. 3711)” is added in its place.

b. The citation “§ 405.374” is removed, and the citation “§ 405.376” is added in its place.

§ 405.1801 [Amended]

8. In § 405.1801, in paragraph (a)(4), the citation “§ 405.374” is removed, and the citation “§ 405.376” is added in its place.

PART 411—EXCLUSIONS FROM MEDICARE AND LIMITATIONS ON MEDICARE PAYMENT

9. The authority citation for part 411 continues to read as follows:

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

§ 411.28 [Amended]

10. In § 411.28, in paragraph (b), the citation “§ 405.374” is removed, and the citation “§ 405.376” is added in its place.

§ 413.20 [Amended]

11. In § 413.20, in paragraph (e), the citation “§ 405.371(a)” is removed wherever it appears (twice), and the citation “§ 405.372(a)” is added in place of the first appearance, and “§ 405.372(b)” is added in place of the second appearance.

§ 413.153 [Amended]

2. In § 413.153, in paragraph (a)(1)(iii), the citation “§ 405.376” is removed, and the citation “§ 405.378” is added in its place.

PART 447—PAYMENTS FOR SERVICES

13. The authority citation for part 447 continues to read as follows:

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

§ 447.31 [Amended]

14. In § 447.31, in paragraph (a), the citation “§ 405.375” is removed, and the citation “§ 405.377” is added in its place.

PART 493—LABORATORY REQUIREMENTS

15. The authority citation for part 493 continues to read as follows:

Authority: Sec. 353 of the Public Health Service Act, secs. 1102, 1861(e), the sentence following 1861(s)(11), 1861(s)(12), 1861(s)(13), 1861(s)(14), 1861(s)(15), and 1861(s)(16) of the Social Security Act (42 U.S.C. 263a, 1302, 1395x(e), the sentence following 1395x(s)(11), 1395(s)(12), 1395(s)(13), 1395(s)(14), 1395(s)(15), and 1395(s)(16)).

§ 493.1834 [Amended]

16. In § 493.1834, in paragraph (i)(1)(ii), the citation “§ 405.376(d)” is removed, and the citation “§ 405.378(d)” is added in its place.

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

Dated: July 30, 1996.

Bruce C. Vladeck,

Administrator, Health Care Financing Administration.

Dated: August 16, 1996.

Donna E. Shalala,

Secretary.

[FR Doc. 96–30057 Filed 11–29–96; 8:45 am]

BILLING CODE 4120–01–P

LEGAL SERVICES CORPORATION

45 CFR Part 1610

Use of Non-LSC Funds

AGENCY: Legal Services Corporation.

ACTION: Final rule.

SUMMARY: This final rule revises the Legal Services Corporation’s (“Corporation” or “LSC”) interim rule concerning the use of non-LSC funds by LSC recipients. The revisions to this rule are intended to implement provisions first appearing in the Corporation’s Fiscal Year (“FY”) 1996 appropriations act that are currently incorporated by reference in the Corporation’s FY 1997 appropriations act. With a few exceptions, many of the new statutory conditions effectively restrict a recipient’s non-LSC funds to the same degree they restrict a recipient’s LSC funds. This rule also clarifies the extent to which conditions on a recipient’s non-LSC funds apply when a recipient transfers its funds to

another person or entity. Technical revisions are also made to the rule.

DATES: This final rule is effective on January 1, 1997.

FOR FURTHER INFORMATION CONTACT: Victor Fortuno, General Counsel, (202) 336–8910.

SUPPLEMENTARY INFORMATION: On May 19, 1996, the Operations and Regulations Committee (“Committee”) of the LSC Board of Directors (“Board”) requested the LSC staff to prepare an interim rule to implement section 504 in the Corporation’s FY 1996 appropriations act, Pub. L. 104–134, 110 Stat. 1321 (1996), which applied most conditions contained therein to any person or entity receiving LSC funds, effectively restricting virtually all of a recipient’s funds to the same degree that it restricts LSC funds. The Committee held hearings on staff proposals on July 8 and 19, and the Board adopted an interim rule on July 20 for publication in the Federal Register. Although the interim rule was effective upon publication, see 61 FR 41960 (August 13, 1996), the Corporation also solicited comments on the rule for review and consideration by the Committee and Board.

The Corporation received 8 comments on the rule. The Committee held public hearings on the rule on September 29, 1996, and made several recommendations for revisions to the Board. The Board adopted this final rule on September 30, 1996.

The Corporation’s FY 1997 appropriations act became effective on October 1, 1996, see Pub. L. 104–208, 110 Stat. 3009. It incorporated by reference the § 504 conditions on LSC grants and other sections of the FY 1996 appropriations act implemented by this rule. Accordingly, the preamble and text of this rule continue to refer to the appropriate section number of the FY 1996 appropriations act.

As did the interim rule, this final rule generally serves two purposes. First, it incorporates the new statutory conditions which apply to both a recipient’s LSC and non-LSC funds. Past appropriations acts applied restrictions contained in those acts only to the funds appropriated thereunder. In contrast, the new statutory provisions prohibit LSC from funding any recipient that engages in certain specified activities or that fails to act in a manner consistent with new statutory requirements. Second, this rule retains several technical revisions made in the interim rule which corrected provisions in the prior rule that had never been revised to be consistent with longstanding amendments to the LSC Act. Finally, in