

because the Federal SIP approval does not impose any new requirements, I certify that it does not have a significant impact on any small entities affected. Moreover, due to the nature of the Federal-State relationship under the Act, preparation of a flexibility analysis would constitute Federal inquiry into the economic reasonableness of State action. The Act forbids EPA to base its actions concerning SIPs on such grounds. See *Union Electric Co. v. U.S. EPA*, 427 U.S. 246, 255–66 (1976); 42 U.S.C. 7410(a)(2).

C. Unfunded Mandates

Under section 202 of the Unfunded Mandates Reform Act of 1995, signed into law on March 22, 1995, EPA must prepare a budgetary impact statement to accompany any proposed or final rule that includes a Federal mandate that may result in estimated costs to State, local, or tribal governments in the aggregate; or to the private sector, of \$100 million or more. Under section 205, EPA must select the most cost-effective and least burdensome alternative that achieves the objectives of the rule and is consistent with statutory requirements. Section 203 requires EPA to establish a plan for informing and advising any small governments that may be significantly or uniquely impacted by the rule.

The EPA has determined that the approval action promulgated does not include a Federal mandate that may result in estimated costs of \$100 million or more to either State, local, or tribal governments in the aggregate, or to the private sector. This Federal action approves preexisting requirements under State or local law, and imposes no new requirements. Accordingly, no additional costs to State, local, or tribal governments, or to the private sector, result from this action.

D. Submission to Congress and the Comptroller General

The Congressional Review Act, 5 U.S.C. 801 *et seq.*, as added by the Small Business Regulatory Enforcement Fairness Act of 1996, generally provides that before a rule may take effect, the agency promulgating the rule must submit a rule report, which includes a copy of the rule, to each House of the Congress and to the Comptroller General of the United States. The EPA will submit a report containing this rule and other required information to the U.S. Senate, the U.S. House of Representatives, and the Comptroller General of the United States prior to publication of the rule in the **Federal Register**. This rule is not a "major rule" as defined by 5 U.S.C. 804(2).

E. Executive Order 13045: Protection of Children From Environmental Health Risks and Safety Risks

This final rule is not subject to E.O. 13045, entitled "Protection of Children from Environmental Health Risks and Safety Risks" (62 FR 19885, April 23, 1997), because this is not an economically significant regulatory action as defined by E.O. 12866. The environmental risks or safety risks addressed by this action do not have a disproportionate effect on children.

F. Petitions for Judicial Review

Under section 307(b)(1) of the Act, petitions for judicial review of this action must be filed in the United States Court of Appeals for the appropriate circuit by August 7, 1998. Filing a petition for reconsideration by the Administrator of this final rule does not affect the finality of this rule for the purposes of judicial review nor does it extend the time within which a petition for judicial review may be filed, and will not postpone the effectiveness of such rule action. This action may not be challenged later in proceedings to enforce its requirements. See section 307(b)(2).

List of Subjects in 40 CFR Part 52

Environmental protection, Air pollution control, Hydrocarbons, Incorporation by reference, Ozone, Reporting and recordkeeping requirements, and Volatile organic compounds.

Dated: May 12, 1998.

Jerry Clifford,

Deputy Regional Administrator, Region 6.

Part 52, chapter I, title 40 of the Code of Federal Regulations is amended as follows:

PART 52—[AMENDED]

1. The authority citation for part 52 continues to read as follows:

Authority: 42 U.S.C. 7401 *et seq.*

Subpart SS—Texas

2. Section 52.2270 is amended by adding paragraph (c)(110) to read as follows:

§ 52.2270 Identification of plan.

* * * * *

(c) * * *

(110) Revision to the Texas State Implementation Plan adopted by the Texas Natural Resource Conservation Commission (TNRCC) on October 15, 1997, and submitted by the Governor on November 12, 1997, repealing the Perchloroethylene Dry Cleaning Systems regulations from the Texas SIP.

(i) Incorporation by reference. TNRCC Order Docket No. 97-0534-RUL issued October 21, 1997, repealing Perchloroethylene Dry Cleaning Systems regulations (Sections 115.521 to 115.529) from 30 TAC Chapter 115.

(ii) Additional materials.

(A) letter from the Governor of Texas dated November 12, 1997, submitting amendments to 30 TAC Chapter 115 for approval as a revision to the SIP.

[FR Doc. 98-15018 Filed 6-5-98; 8:45 am]

BILLING CODE 6560-50-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Part 420

[HCFA-6144-FC]

RIN 0938-AH86

Medicare Program; Incentive Programs-Fraud and Abuse

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

ACTION: Final rule with comment period.

SUMMARY: This final rule with comment period establishes a program for payment to individuals who provide information on Medicare fraud and abuse or other sanctionable activities. This final rule implements section 203(b) of the Health Insurance Portability and Accountability Act of 1996.

DATES: *Effective date:* This final rule is effective July 8, 1998. *Comment period:* Comments will be considered if we receive them at the appropriate address, as provided below, no later than 5 p.m. on August 7, 1998.

ADDRESSES: Mail written comments (1 original and 3 copies) to the following address: Health Care Financing Administration, Department of Health and Human Services, Attention: HCFA-6144-FC, P.O. Box 26688, Baltimore, MD 21207-0488.

If you prefer, you may deliver your written comments (1 original and 3 copies) to one of the following addresses:

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

FOR FURTHER INFORMATION CONTACT: Delilah Schmitt, (410) 786-4300.

SUPPLEMENTARY INFORMATION: Comments may also be submitted electronically to

the following e-mail address:

hcfa6144fc@hcfa.gov. E-mail comments must include the full name and address of the sender and must be submitted to the referenced address to be considered. All comments must be incorporated in the e-mail message because we may not be able to access attachments. Electronically submitted comments will be available for public inspection at the Independence Avenue address below.

Because of staffing and resource limitations, we cannot accept comments by facsimile (FAX) transmission. In commenting, please refer to file code HCFA-6144-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 Avenue, SW., Washington, DC, on Monday through Friday of each week from 8:30 a.m. to 5 p.m. (phone: (202) 690-7890).

I. Rewards for Information Relating to Medicare Fraud and Abuse

A. Background

Section 203(b)(1) of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191) instructs the Secretary to establish a program to encourage individuals to report information on individuals and entities that are engaged in or have engaged in acts or omissions that constitute grounds for the imposition of a sanction under section 1128, 1128A, or 1128B of the Social Security Act (the Act) or who have otherwise engaged in sanctionable fraud and abuse against the Medicare program under title XVIII of the Act. By increasing the incentives for concerned citizens to report evidence of suspected fraudulent behavior, Congress hopes to protect beneficiaries and the Medicare Trust Funds.

Section 203(b)(2) of Public Law 104-191 authorizes the Secretary to pay a reward to individuals who provide information under the program established under section 203(b)(1) if the information leads to the recovery of at least \$100 (excluding penalties under section 1128B of the Act) by the Secretary or the Attorney General of the United States. Public Law 104-191 requires the reward to come from the amounts collected. The Statute also addresses a suggestion program. We are still analyzing the most effective methods for implementing this requirement and will address it in subsequent rulemaking.

B. Provisions of this Final Rule

This rule adds a new Subpart E, consisting of §§ 420.400 through 420.405, to 42 CFR part 420 ("Program Integrity: Medicare). New Subpart E includes provisions to implement section 203(b) of Public Law 104-191 and is entitled as "Rewards for Information Relating to Medicare Fraud and Abuse".

Section § 420.400 sets forth the statutory basis and scope of Subpart E.

Section § 420.405 sets forth our policies regarding, and procedures for, rewarding individuals for furnishing information relating to Medicare fraud and abuse. The statute contains no provisions limiting or restricting our discretion in determining the rewards to be granted under the program established under section 203(b). Therefore, in paragraph (a) of § 420.405, we specify that when HCFA exercises its discretion in determining that someone is eligible for a reward and the reward amount, the reward will be granted and the individual notified according to the procedures in § 420.405(d). Further, we specify that we may make a monetary reward only for information that leads to a minimum recovery of \$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 fraud and abuse against the Medicare program under title XVIII of the Act and for which there is a sanction provided under law. This provision, which is specifically mandated in the authorizing statute, ensures that a reward is paid only if Medicare funds are recovered because of the commission of certain specifically sanctionable offenses. These include the defrauding of the Medicare program or the offering of or solicitation of kickbacks for services payable by Medicare. Individuals who furnish information concerning actions or omissions for which there are no sanctions at law are not eligible to receive a reward under this program even if the information leads to the recovery of Medicare payments.

Finally, in order to ensure that the program does not duplicate other Government incentive programs, we also specify, in paragraph (a), that we may pay rewards only in instances in which a reward is not otherwise provided at law. That is, if the information furnished qualifies the participant for a reward under another Government program, the individual is

not entitled to a reward under this program.

Paragraph (b) of § 420.405 specifies the information that would be required in order for a participant to be eligible to receive a reward. Section 203(b)(1) of Public Law 104-191 requires that the reward program discourage the submission of information that is frivolous or otherwise not relevant or material to the imposition of a sanction. Such information will not be considered by the Secretary. Therefore, we have developed criteria to ensure that only individuals who provide information that directly contributes to the recovery of Medicare funds from a fraudulent provider or supplier are considered for a reward. Those criteria are discussed below.

Paragraph (b)(1) of § 420.405 specifies that, in order for an individual to qualify for a reward, the information furnished by that individual must relate to a specific situation, individual, or entity, and must specify the time period of the alleged activities. This provision is intended to discourage individuals from furnishing information of a general nature and to ensure that information submitted be of assistance in the investigation of a specific sanctionable offense. To be of assistance in the development of an investigation, information must relate to specific actions by a specific individual or entity. Any information that is too general in nature (for example, "Medicare should look into home health agencies in Smith County") is of little or no use in targeting scarce investigation resources and does not show that the individual has any specific knowledge of wrongdoing on the part of a certain individual or entity. An example of the kind of information that would meet the requirements of this provision would be that a particular home health agency is billing Medicare for visits not actually furnished.

Paragraph (b)(2) of § 420.405 specifies that we do not give a reward for the submission of information relating to sanctionable activities already known or suspected by the Government, its contractors, or State or local law enforcement agencies. Accordingly, 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 us, our contractors, or the Office of Inspector General (OIG), the Department of Justice, the Federal Bureau of Investigation, or any other Federal, State, or local law enforcement agency would not serve as the "basis for the collection" and could not be compensated. Paragraph (c) of § 420.405

sets forth the criteria that an individual must meet in order to be eligible for a reward. Paragraph (c)(1) provides that any person, other than one excluded under paragraph (c)(2), is eligible to receive a reward under the reward program if he or she submits the information in the prescribed manner (discussed later in this preamble). Accordingly, Medicare beneficiaries, Medicare providers, and any other individuals may be eligible to receive awards under this reward program.

Paragraph (c)(2) specifies who is ineligible to receive a reward under the reward program. Specifically, paragraph (c)(2)(i) provides that an individual who was or is an immediate family member of an officer or employee of the Department of Health and Human Services (HHS) or its contractors, the Social Security Administration, a State Medicaid agency, the OIG, 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 reported information leading to a recovery of Medicare funds is not eligible to receive a reward. Paragraph (c)(2)(ii) specifies that any other Federal or State employee or contractor or HHS grantee is not eligible for a reward if he or she acquired the submitted information in the course of his or her official duties.

The purpose of the exclusion is to prevent Government employees, contractors, or grantees from personally profiting from information gained while doing public business. These individuals may, in the course of performing their official duties, obtain information relating to sanctionable offenses by individuals or entities providing services under the Medicare program. As a responsibility of their position, however, these individuals are obligated to take the necessary steps to ensure that this information is reported to the appropriate authorities. This exclusion also applies to former employees of the specified organizations if the information in question was obtained during their employment. Similarly, any other Federal, State, or local government employee or contractor or HHS grantee is excluded from receiving a reward under this reward program if the information was obtained in the course of his or her official duties. As with the previous exclusion, this exclusion is intended to prevent individuals from personally profiting from information gained in the course of conducting public business.

Paragraph (c)(2)(iii) excludes any individual who illegally obtained the information he or she submitted from

receiving a reward under this program. Paragraph (c)(2)(iv) excludes any participants in the alleged sanctionable offense with respect to which payment would be made from receiving a reward under this program. These exclusions are intended to prevent those who have violated the law from profiting from their actions at the expense of this program.

Paragraph (d) of § 420.405 sets forth reward notification procedures. Paragraph (d)(1) specifies that, as a general rule, we notify an individual of his or her eligibility to receive a reward, by letter sent to the individual's last known address. Paragraph (d)(1) further specifies that the notification is sent after Medicare funds have been recovered and a participant has been determined eligible to receive a reward. We add that it is the individual's responsibility to provide all relevant information and to ensure that the reward program is notified of any changes in that information.

Paragraph (d)(2) provides that an individual has up to 1 year from the date on the notification letter to claim his or her reward. This paragraph also specifies that no interest is paid on rewards that are not immediately claimed.

Paragraph (d)(2) also specifies that, if the participant has become incapacitated or died, an executor, administrator, or other legal representative may claim the reward on behalf of the participant or participant's estate. In order to protect participants from being defrauded by individuals falsely claiming to be their legal representatives, we add that the claimant must submit certified copies of letters testamentary, letters of administration, or other similar evidence to show his or her authority to claim the reward. Here, again, we specify that the reward must be claimed within 1 year from the date on which we mailed notification to the participant.

We have set these 1-year limitations to minimize the administrative burden associated with the reward program. We believe 1 year is a reasonable period of time during which an individual may claim his or her reward. In addition, the 1-year limitation protects the Government from the administrative and fiscal burden that would be associated with maintaining claims for a longer or indefinite period. Rewards not claimed within 1 year from the date of the notification letter will not be awarded.

In paragraph (e) of § 420.405, we establish the limits on rewards and set forth the processes by which we

determine whether we will pay a reward and, if a reward is to be paid, the amount of the reward. Paragraph (e)(1) specifies that, in determining whether we will pay a reward, and the amount of the reward, we take into consideration 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.

To give participants a realistic expectation of potential reward amounts, we establish general guidelines for the calculation of the amount of any reward and a maximum potential reward amount. Since the primary goal of this program is to preserve and protect the Medicare Trust Funds, and because the funds used for rewards under the program will come from recovered trust fund monies, it would be inappropriate to grant excessive or overly-generous rewards. Therefore, § 420.405(e)(2) specifies that the amount of a reward represents what we consider 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. We believe this approach provides adequate compensation and notification to those individuals who provide important information on sanctionable activities, while also establishing an objective limit on Trust Fund disbursements.

We anticipate that some commenters will object to this limit as being too low. In response, we point out that persons with information on individuals or entities purportedly defrauding the Medicare program also have the option of initiating a "qui tam" action against the fraudulent individual or entity in cooperation with the Government. (A qui tam action is an action brought by a private individual, under a statute that establishes a penalty for the commission or omission of a certain act that is recoverable in a civil action. In a qui tam action, an individual brings the civil action on behalf of him or herself and the Government, State, or other entity. Part of any collected penalty goes to the person who brings the civil action.)

We determine reward amounts on a case by case basis. Section 420.405(e)(3) specifies that, if more than one participant provides information that leads to the recovery of Medicare funds, we allocate the overall reward (not to exceed 10 percent of the overpayments recovered in that case or \$1,000, whichever is less) among the total number of participants. Again, this provision is intended to protect the

Medicare Trust Funds to the greatest possible extent.

In accordance with section 203(b)(2) of Public Law 104-191, § 420.405(e)(4) specifies that rewards are based solely on recovered Medicare payments and not on amounts collected as penalties or fines. Section 420.405(e)(5) specifies that rewards are awarded only after all overpayments, fines, and penalties have been collected. It is important for participants to understand that the investigation, development, and prosecution or settlement of a fraud case is a complicated and lengthy process. Given the material and human resource constraints, it is not unusual for 3 to 5 years to elapse before fraudulently-obtained Medicare funds are recovered and any applicable fines or penalties collected. This means that, on average, a participant who provides information that leads to a Medicare recovery from an individual or entity that committed a sanctionable offense would have to wait several years before receiving a reward under this program.

Section 420.405(e)(6) specifies that no person may make any offer or promise or otherwise bind us or HHS with respect to the payment of any reward or the amount of the reward.

Paragraph (f) of § 420.405 describes the procedure individuals must follow when submitting information in order to be eligible to receive a reward under this program. Paragraph (f)(1) provides that an individual may submit information to us on individuals and/or entities allegedly engaging in, or that have allegedly engaged in, fraud and abuse against the Medicare program by calling the Office of Inspector General or the Medicare intermediary or carrier that has jurisdiction over the suspected fraudulent provider or supplier.

Paragraph (f)(2) of § 420.405 adds that an individual 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. An individual may elect to furnish information to the Office of the Inspector General, or to the intermediary or carrier anonymously. However, if an individual elects to do so, he or she would not be eligible to receive a reward under this program.

Section 420.405(g) specifies that we do not disclose the participant's identity to any persons except as required by law. Finally, § 420.405(h) specifies that, if, after an award had been accepted, the awardee is determined ineligible to receive a reward under this program, the

Government is not liable for the reward and the awardee must refund all monies received. This provision is intended to protect the Government from paying rewards to individuals it later finds were not eligible to participate in the program. For example, the Government would recover a reward granted to a participant who was later found to have participated in the sanctionable offense with respect to which payment was made.

II. Response to Comments

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

III. Regulatory Impact Analysis

A. Introduction

We have examined the impact of this rule as required by Executive Order 12866 and the Regulatory Flexibility Act (RFA) (Public Law 96-354). Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and governmental agencies. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of \$5 million or less annually. Individuals are not considered to be small entities.

Section 1102(b) of the Social Security Act requires us to prepare a regulatory impact analysis for any rule that may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. For purposes of section 1102(b), we define a small rural hospital as a hospital that is located outside a Metropolitan Statistical Area and has fewer than 50 beds.

B. Summary of This Rule

This rule establishes a payment system as a means of encouraging

individuals to report instances of suspected fraud and abuse or other sanctionable activities under the Medicare program. The rule delineates program parameters, information requirements, eligibility criteria, establishes an upper limit for payments, defines proportionate distribution in cases of multiple informants, and outlines the process and time limitations for obtaining a reward.

C. Discussion of Impact

This rule is expected to affect beneficiaries, their personal representatives, providers, physicians, other suppliers, and managed care plans. (We have separate authority to impose intermediate sanctions against managed care plans participating in the Medicare program. The law also permits the Office of Inspector General to impose civil money penalties on the health maintenance organization or competitive medical plan as set forth in 42 CFR part 1003.) Taxpayers and the trust fund could also be impacted by this rule.

Beneficiaries as a group are expected to be impacted by this regulation in a variety of ways. First, beneficiaries are often the first to recognize and question provider practices. This regulation encourages these individuals to share such information with the agency by (1) providing a clearly defined process for submitting information to the appropriate source and (2) offering a monetary incentive to support the effort. Secondly, this group would benefit from fraud reduction through greater confidence in the program and its continued financial viability. Some beneficiaries may or may not be motivated by a reward system to report fraudulent provider activity because of a perceived potential for breaching the provider/patient relationship.

Notwithstanding some minimal hesitancy in reporting fraud, beneficiaries are already one of our strongest allies in quickly detecting and providing us with a great many leads about instances of fraud and abuse in the Medicare program. Beneficiaries are asked to review the Explanation of Medicare Benefits form, which lists services and charges and is sent to each beneficiary when a service is furnished, and report any discrepancies concerning those services to the Medicare contractor serving their area. Medicare contractors estimate that of the 130,000 calls they receive yearly concerning potential fraud and abuse, 94,000 are from beneficiaries, many of whom call to question the propriety of claims made on their behalf. We estimate that there will be a 5 or 10 percent increase in the

volume of calls received as a result of this monetary reward incentive program. We support this activity by regularly advising beneficiaries and their representatives about opportunities to preserve trust fund dollars and how they can help combat fraud and abuse.

Fraud, waste, and abuse in medical care encompass a wide range of practices, limited only by the scope of human imagination. To the fraudulent provider of health care services, fee-for-service reimbursement provides the opportunity for: (1) Billing for services not provided; (2) billing for a more expensive service than was actually provided; (3) providing and billing for unnecessary services; (4) paying kickbacks for referrals, including self-referrals; and (5) duplicate billing. Two fraudulent schemes involving falsifying records and overcharging include "upcoding" and "unbundling." Upcoding involves switching primary and secondary diagnoses to substitute more costly procedures and services than were actually administered to the patient. Unbundling involves improperly separately billing for procedures that should be billed for under one code.

Under managed care, fraudulent and abusive practices may include: (1) Enrolling beneficiaries without their active consent; (2) engaging in deceptive marketing practices to entice enrollment; (3) denying medically necessary services; and (4) failure to disclose appeal rights.

We believe the exact amount of improper billing and health care fraud are difficult to quantify because of their hidden nature. However, a Government Accounting Office (GAO) report on Medicare (GAO/HR-91-10, February 1997) suggests that by reducing unnecessary or inappropriate payments, the Federal Government would realize large savings and help dampen the growth in Medicare costs. In this report, the GAO states that estimates of the costs of fraud and abuse, ranging from 3 to 10 percent, have been cited for health expenditures nationwide, "so applying this range to Medicare suggests that such losses in fiscal year 1996 could range from \$6 billion to as much as \$20 billion." Program savings would be offset by the amount of incentives awarded under this rule. The total amount of awards made in any year is unknown but is expected to be nominal.

Overall, we expect that providers and suppliers will benefit qualitatively from this rule. Not only do many providers and suppliers perceive that their reputations are tarnished by the few dishonest providers and suppliers that

take advantage of the Medicare program, but some providers may have ideas that could minimize the impact of this adverse behavior. The media often focus on the most egregious cases of Medicare fraud and abuse, leaving the public with the misperception that physicians and other health care practitioners routinely make improper claims. This rule encourages individuals to report instances of suspected fraud and abuse. As the number of dishonest providers and suppliers and improper claims diminishes, ethical providers and suppliers will benefit.

This rule could be considered to have a negative impact on any provider or supplier that routinely submits questionable claims and those that have been receiving inappropriate payments, including managed care plans. Since one objective of this rule is to eliminate improper payments, we will not analyze the effect the rule may have on unscrupulous providers or suppliers. We do not believe that this rule will reduce a provider's or supplier's legitimate income from Medicare.

The reporting of instances of suspected fraud and abuse or other sanctionable activities is not expected to impose a paperwork burden on individuals participating in this award program. Beneficiaries and other participating entities are expected to rely upon existing record collection, record keeping, review and reporting processes similar to those already in use.

D. Conclusion

We conclude that money would be saved, and the solvency of the Trust Funds extended as a result of this rule. The growing complexity of the Medicare program easily lends itself to objective critiques by those who are most affected by the myriad of Medicare statutes, provisions, and guidelines. In addition, the dynamic nature of fraud and abuse, as illustrated by the fact that wrongdoers continue to find ways to evade safeguards, supports the need for constant vigilance and increasingly sophisticated ways to protect against "gaming" of the system.

Based on the above analysis, we have determined, and certify, that this rule will not have a significant economic impact on a substantial number of small entities. We also have determined, and certify, that this rule 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 rule was not reviewed by the Office of Management and Budget.

E. Waiver of Proposed Rulemaking

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** and invite public comment on the proposed rule. The notice of proposed rulemaking includes a reference to the legal authority under which the rule is proposed, and the terms and substances of the proposed rule or a description of the subjects and issues involved. This procedure can be waived, however, if an agency finds good cause that a notice-and-comment procedure is impracticable, unnecessary, or contrary to the public interest and incorporates a statement of the finding and its reasons in the rule issued.

Publishing this rule expeditiously to supplement activities that identify and curtail fraud and abuse activities that reduce the monetary drain on the Medicare trust fund is in the public interest. Specifically, we anticipate that the implementation of this rule will encourage individuals to report potentially fraudulent and abusive activities and we anticipate that such reports will facilitate expeditious recovery of money owed to the Medicare trust funds. Further delaying implementation of this program in order to give the public an opportunity to comment would deprive individuals of the financial incentives that Congress intended to provide to individuals who come forward with relevant information. Additional delay following the publication of a proposed rule may cause some individuals to withhold information necessary to support the Government's efforts until final rules are effective. Because the delay may make it more difficult to successfully complete investigation of those cases, waiving notice and comment clearly is within the public interest.

Therefore, we find good cause to waive the notice of proposed rulemaking and to issue this final rule with comment period. We are providing a 60-day comment period for public comment.

List of Subjects in 42 CFR Part 420

Fraud, Health facilities, Health professions, Incentive programs, Medicare.

For the reasons set forth in the preamble, 42 CFR part 420 is amended as set forth below:

PART 420—PROGRAM INTEGRITY: MEDICARE

1. The authority citation for part 420 continues to read as follows:

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

2. A new subpart E is added to part 420 to read as follows:

Subpart E—Rewards for Information Relating to Medicare Fraud and Abuse

Sec.

420.400 Basis and scope.

420.405 Rewards for information relating to Medicare fraud and abuse.

Subpart E—Rewards for Information Relating to Medicare Fraud and Abuse

§ 420.400 Basis and scope.

This subpart implements section 203 (b) of Public Law 104–191, which requires the establishment of a program to encourage individuals to report suspected cases of fraud and abuse. Sections 203 (b) of Public Law 104–191 also provides the authority for HCFA to reward individuals for reporting fraud and abuse. This subpart sets forth procedures for rewarding individuals.

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

(a) *General rule.* HCFA 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 HCFA. HCFA pays rewards only if a reward is not otherwise provided for by law. When HCFA 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 recipient 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) HCFA 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 HCFA 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.

(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 HCFA 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 HCFA within 1 year from the date on which HCFA first attempted to notify the individual about a reward. HCFA 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. HCFA 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 HCFA 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, HCFA 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 HCFA 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, HCFA 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) HCFA bases rewards only on recovered Medicare payments and not on amounts collected as penalties or fines.

(5) HCFA 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 HCFA 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.* HCFA 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, HCFA finds that the awardee was ineligible to receive the reward, the

Government is not liable for the reward and the awardee must refund all monies received.

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

Dated: April 4, 1998.

Nancy-Ann Min DeParle,

*Administrator, Health Care Financing
Administration.*

Dated: June 2, 1998.

Donna E. Shalala,

Secretary.

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