

not required to estimate the change in reimbursement and return the estimated overpayment until the final reconciliation of that cost report.

(d) *Reporting.* (1) A person must use an applicable claims adjustment, credit balance, self-reported refund, or other reporting process set forth by the applicable Medicare contractor to report an overpayment, except as provided in paragraph (d)(2) of this section. If the person calculates the overpayment amount using a statistical sampling methodology, the person must describe the statistically valid sampling and extrapolation methodology in the report.

(2) A person satisfies the reporting obligations of this section by making a disclosure under the OIG’s Self-Disclosure Protocol or the CMS Voluntary Self-Referral Disclosure Protocol resulting in a settlement agreement using the process described in the respective protocol.

(e) *Enforcement.* Any overpayment retained by a person after the deadline for reporting and returning the overpayment specified in paragraph (b) of this section is an obligation for purposes of 31 U.S.C. 3729.

(f) *Lookback period.* An overpayment must be reported and returned in accordance with this section if a person identifies the overpayment, as defined in paragraph (a)(2) of this section, within 6 years of the date the overpayment was received.

Subpart E [Reserved]

Subpart F—Claims Collection and Compromise

SOURCE: 48 FR 39064, Aug. 29, 1983, unless otherwise noted.

§ 401.601 Basis and scope.

(a) *Basis.* This subpart implements the following statutory provisions:

(1) For CMS the Debt Collection Improvement Act of 1996 (Pub. L. 104–134) (DCIA), 110 Stat. 1321, 1358 (April 26, 1996) (codified at 31 U.S.C. 3711), and conforms to the regulations (31 CFR parts 900–904) issued jointly by the Department of the Treasury and the Department of Justice that generally prescribe claims collection standards and

procedures under the DCIA for the Federal government.

(2) Section 1893(f)(1) of the Act regarding the use of repayment plans.

(b) *Scope.* Except as provided in paragraphs (c) through (f) of this section, the regulations in this subpart describe CMS’s procedures and standards for the collection of claims in any amount, and the compromise of, or the suspension or termination of collection action on, all claims for money or property that do not exceed \$100,000 or such higher amount as the Attorney General may from time to time prescribe, exclusive of interest, arising under any functions delegated to CMS by the Secretary.

(c) *Amount of claim.* CMS refers all claims that exceed \$100,000 or such higher amount as the Attorney General may from time to time prescribe, exclusive of interest, to the Department of Justice or the General Accounting Office for the compromise of claims, or the suspension or termination of collection action.

(d) *Related regulations*—(1) *Department regulations.* DHHS regulations applicable to CMS that generally implement the FCCA for the Department are located at 45 CFR part 30. These regulations apply only to the extent CMS regulations do not address a situation.

(2) *CMS regulations.* The following regulations govern specific debt management situations encountered by CMS and supplement this subpart:

(i) Claims against Medicare beneficiaries for the recovery of overpayments are covered in 20 CFR 404.515.

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

(iii) Claims against providers, physicians, or other suppliers of services for overpayments under Medicare and for assessment of interest are covered in §§ 405.377 and 405.378 of this chapter, respectively.

(iv) Claims against beneficiaries for unpaid hospital insurance or supplementary medical insurance premiums under Medicare are covered in § 408.110 of this chapter.

(v) State repayment of Medicaid funds by installments is covered in § 430.48 of this chapter.

(e) *Collection and compromise under other statutes and at common law.* The regulations in this subpart do not—

(1) Preclude disposition by CMS of claims under statutes, other than the FCCA, that provide for the collection or compromise of a claim, or suspension or termination of collection action.

(2) Affect any rights that CMS may have under common law as a creditor.

(f) *Fraud.* The regulations in this subpart do not apply to claims in which there is an indication of fraud, the presentation of a false claim, or misrepresentation on the part of a debtor or any other party having an interest in the claim. CMS forwards these claims to the Department of Justice for disposition under 4 CFR 105.1.

(g) *Enforced collection.* CMS refers claims to the Department of Justice for enforced collection through litigation in those cases which cannot be compromised or on which collection action cannot be suspended or terminated in accordance with this subpart or the regulations issued jointly by the Attorney General and the Comptroller General.

[48 FR 39064, Aug. 29, 1983, as amended at 52 FR 48123, Dec. 18, 1987; 57 FR 56998, Dec. 2, 1992; 61 FR 49271, Sept. 19, 1996; 61 FR 63748, Dec. 2, 1996; 73 FR 36447, June 27, 2008]

§ 401.603 Definitions.

For purposes of this subpart—

Claim means any debt owed to CMS.

Debtor means any individual, partnership, corporation, estate, trust or other legal entity against which CMS has a claim.

Extended repayment schedule means installment payments to pay back a debt.

[48 FR 39064, Aug. 29, 1983, as amended at 73 FR 36447, June 27, 2008]

§ 401.605 Omissions not a defense.

The failure of CMS to comply with the regulations in this subpart, or with the related regulations listed in § 401.601(d), is not available as a defense to a debtor against whom CMS has a claim for money or property.

§ 401.607 Claims collection.

(a) *General policy.* CMS recovers amounts of claims due from debtors, including interest where appropriate, by—

(1) Direct collections in lump sums or in installments; or

(2) Offsets against monies owed to the debtor by the Federal government where possible.

(b) *Collection in lump sums.* Whenever possible, CMS attempts to collect claims in full in one lump sum. However, if CMS determines that a debtor is unable to pay the claim in one lump sum, CMS may instead enter into an agreement to accept regular installment payments.

(c) *Collection in installments.* Generally, CMS requires that all claims to be satisfied by installment payments must be liquidated in three years or less. If unusual circumstances exist, such as the possibility of debtor insolvency, an installment agreement that extends beyond three years may be approved.

(1) *Debtor request.* If a debtor desires to repay a claim in installments, the debtor must submit—

(i) A request to CMS; and

(ii) Any information required by CMS to make a decision regarding the request.

(2) *Extended repayment schedule.* (i) For purposes of this paragraph (c)(2), the following definitions apply:

Extreme hardship exists when a provider or supplier qualifies as being in “hardship” as defined in this paragraph and the provider’s or supplier’s request for an extended repayment schedule (ERS) is approved under paragraph (c)(3) of this section.

Hardship exists when the total amount of all outstanding outstanding overpayments (principal and interest and including overpayments reported in accordance with §§ 401.301 through 401.305) not included in an approved, existing repayment schedule is 10 percent or greater than the total Medicare payments made for the cost reporting period covered by the most recently submitted cost report for a provider filing a cost report, or for the previous calendar year for a supplier or non cost-report provider.

(ii) CMS or its contractor reviews a provider's or supplier's request for an ERS. For a provider or a supplier not paid by Medicare during the previous year or paid only during a portion of that year, the contractor or CMS will use the last 12 months of Medicare payments. If less than a 12-month payment history exists, the number of months available is annualized to equal an approximate yearly Medicare payment level for the provider or supplier.

(iii) For a provider or supplier requesting an ERS, CMS or its contractor evaluates the request based on the definitions and information submitted under this paragraph (c)(2). For a provider or supplier whose situation does not meet the definitions in paragraph (c)(2)(i) of this section, CMS or its contractor evaluates the ERS request using the information in paragraph (c)(3) of this section in deciding to grant an ERS.

(iv) CMS or its contractor is prohibited from granting an ERS to a provider or supplier if there is reason to suspect the provider or supplier may file for bankruptcy, cease to do business, discontinue participation in the Medicare program, or there is an indication of fraud or abuse committed against the Medicare program.

(v) CMS or its contractor may grant a provider or a supplier an ERS of at least 6 months if repaying an overpayment within 30 days will constitute a "hardship" as defined in paragraph (c)(2)(i) of this section. If a provider or supplier is granted an ERS under this paragraph, missing one installment payment constitutes a default and the total balance of the overpayment will be recovered immediately.

(vi) CMS or its contractor may grant a provider or a supplier an ERS of 36 months and up to 60 months if repaying an overpayment will constitute an "extreme hardship" as defined in paragraph (c)(2)(i) of this section.

(3) *CMS decision.* CMS will determine the number, amount and frequency of installment payments based on the information submitted by the debtor and on other factors such as—

- (i) Total amount of the claim;
- (ii) Debtor's ability to pay; and
- (iii) Cost to CMS of administering an installment agreement.

(d) *Collection by offset.* (1) CMS may offset, where possible, the amount of a claim against the amount of pay, compensation, benefits or other monies that a debtor is receiving or is due from the Federal government.

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

[48 FR 39064, Aug. 29, 1983, as amended at 61 FR 49271, Sept. 19, 1996; 61 FR 63748, Dec. 2, 1996; 73 FR 36447, June 27, 2008; 81 FR 7684, Feb. 12, 2016]

§ 401.613 Compromise of claims.

(a) *Amount of compromise.* HFCA requires that the amount to be recovered through a compromise of a claim must—

(1) Bear a reasonable relation to the amount of the claim; and

(2) Be recoverable through enforced collection procedures.

(b) *General factors.* After considering the bases for a decision to compromise a claim under paragraph (c) of this section, CMS may further consider factors such as—

(1) The age and health of the debtor if the debtor is an individual;

(2) Present and potential income of the debtor; and

(3) Whether assets have been concealed or improperly transferred by the debtor.

(c) *Basis for compromise.* Bases on which CMS may compromise a claim include the following—

(1) *Inability to pay.* CMS may compromise a claim if it determines that the debtor, or the estate of a deceased debtor, does not have the present or prospective ability to pay the full amount of the claim within a reasonable time.

(2) *Litigative probabilities.* CMS may compromise a claim if it determines that it would be difficult to prevail in a case before a court of law as a result of the legal issues involved or inability of the parties to agree to the facts of

the case. The amount that CMS accepts in compromise under this provision will reflect—

(i) The likelihood that CMS would have prevailed on the legal question(s) involved;

(ii) Whether and to what extent CMS would have obtained a full or partial recovery of a judgment, depending on the availability of witnesses, or other evidentiary support for CMS's claim; and

(iii) The amount of court costs that would be assessed to CMS.

(3) *Cost of collecting the claim.* CMS may compromise a claim if it determines that the cost of collecting the claim does not justify the enforced collection of the full amount. In this case, CMS may adjust the amount it accepts as a compromise to allow an appropriate discount for the costs of collection it would have incurred but for the compromise.

(d) *Enforcement policy.* CMS may compromise statutory penalties, forfeitures, or debts established as an aid to enforcement or to compel compliance, if it determines that its enforcement policy, in terms of deterrence and securing compliance both present and future, is adequately served by acceptance of the compromise amount.

§ 401.615 Payment of compromise amount.

(a) *Time and manner of compromise.* Payment by the debtor of the amount that CMS has agreed to accept as a compromise in full settlement of a claim must be made within the time and in the manner prescribed by CMS. Accordingly, CMS will not settle a claim until the full payment of the compromise amount has been made.

(b) *Effect of failure to pay compromise amount.* Failure of the debtor to make payment, as provided by the compromise agreement, reinstates the full amount of the claim, less any amounts paid prior to the default.

(c) *Prohibition against grace periods.* CMS will not agree to inclusion of a provision in an installment agreement that would permit grace periods for payments that are late under the terms of the agreement.

§ 401.617 Suspension of collection action.

(a) *General conditions.* CMS may temporarily suspend collection action on a claim if the following general conditions are met—

(1) *Amount of future recovery.* CMS determines that future collection action may result in a recovery of an amount sufficient to justify periodic review and action on the claim by CMS during the period of suspension.

(2) *Statute of limitations.* CMS determines that—

(i) The applicable statute of limitations has been tolled, waived or has started running anew; or

(ii) Future collections may be made by CMS through offset despite an applicable statute of limitations.

(b) *Basis for suspension.* Bases on which CMS may suspend collection action on a particular claim include the following—

(1) A debtor cannot be located; or

(2) A debtor—

(i) Owns no substantial equity in property;

(ii) Is unable to make payment on CMS's claim or is unable to effect a compromise; and

(iii) Has future prospects that justify retention of the claim.

(c) *Locating debtors.* CMS will make every reasonable effort to locate missing debtors sufficiently in advance of the bar of an applicable statute of limitations to permit timely filing of a lawsuit to recover the amount of the claim.

(d) *Effect of suspension on liquidation of security.* CMS will liquidate security, obtained in partial recovery of a claim, despite a decision under this section to suspend collection action against the debtor for the remainder of the claim.

§ 401.621 Termination of collection action.

(a) *General factors.* After considering the bases for a decision to terminate collection action under paragraph (b) of this section, CMS may further consider factors such as—

(1) The age and health of the debtor if the debtor is an individual;

(2) Present and potential income of the debtor; and

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(3) Whether assets have been concealed or improperly transferred by the debtor.

(b) *Basis for termination of collection action.* Bases on which CMS may terminate collection action on a claim include the following—

(1) *Inability to collect a substantial amount of the claim.* CMS may terminate collection action if it determines that it is unable to collect, or to enforce collection, of a significant amount of the claim. In making this determination, CMS will consider factors such as—

- (i) Judicial remedies available;
- (ii) The debtor's future financial prospects; and
- (iii) Exemptions available to the debtor under State or Federal law.

(2) *Inability to locate debtor.* In cases involving missing debtors, CMS may terminate collection action if—

- (i) There is no security remaining to be liquidated;
- (ii) The applicable statute of limitations has run; or
- (iii) The prospects of collecting by offset, whether or not an applicable statute of limitations has run, are considered by CMS to be too remote to justify retention of the claim.

(3) *Cost of collection exceeds recovery.* CMS may terminate collection action if it determines that the cost of further collection action will exceed the amount recoverable.

(4) *Legal insufficiency.* CMS may terminate collection action if it determines that the claim is legally without merit.

(5) *Evidence unavailable.* CMS may terminate collection action if—

- (i) Efforts to obtain voluntary payment are unsuccessful; and
- (ii) Evidence or witnesses necessary to prove the claim are unavailable.

§ 401.623 Joint and several liability.

(a) *Collection action.* CMS will liquidate claims as quickly as possible. In cases of joint and several liability among two or more debtors, CMS will not allocate the burden of claims payment among the debtors. CMS will proceed with collection action against one debtor even if other liable debtors have not paid their proportionate shares.

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(b) *Compromise.* Compromise with one debtor does not release a claim against remaining debtors. Furthermore, CMS will not consider the amount of a compromise with one debtor to be a binding precedent concerning the amounts due from other debtors who are jointly and severally liable on the claim.

§ 401.625 Effect of CMS claims collection decisions on appeals.

Any action taken under this subpart regarding the compromise of a claim, or suspension or termination of collection action on a claim, is not an initial determination for purposes of CMS appeal procedures.

Subpart G—Availability of Medicare Data for Performance Measurement

SOURCE: 76 FR 76567, Dec. 7, 2011, unless otherwise noted.

§ 401.701 Purpose and scope.

The regulations in this subpart implement section 1874(e) of the Social Security Act as it applies to Medicare data made available to qualified entities for the evaluation of the performance of providers and suppliers.

§ 401.703 Definitions.

For purposes of this subpart:

(a) *Qualified entity* means either a single public or private entity, or a lead entity and its contractors, that meets the following requirements:

- (1) Is qualified, as determined by the Secretary, to use claims data to evaluate the performance of providers and suppliers on measures of quality, efficiency, effectiveness, and resource use.
- (2) Agrees to meet the requirements described in this subpart at §§ 401.705 through 401.721.

(b) *Provider of services (referred to as a provider)* has the same meaning as the term “provider” in § 400.202 of this chapter.

(c) *Supplier* has the same meaning as the term “supplier” at § 400.202 of this chapter.

(d) *Claim* means an itemized billing statement from a provider or supplier that, except in the context of Part D prescription drug event data, requests