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July 11, 2014

Ms. Patrice Drew  
Office of Inspector General  
Department of Health and Human Services  
Attention: OIG-403-P  
Cohen Building  
330 Independence Avenue SW  
Room 5541C  
Washington, DC 20201

***RE: OIG-403-P: Medicare and State Health Care Programs: Fraud and Abuse; Revisions to the Office of Inspector General's Civil Monetary Penalty Rules; Proposed Rule***

Dear Ms. Drew:

The American Health Care Association (AHCA) appreciates the opportunity to comment on the *Medicare and State Health Care Programs: Fraud and Abuse; Revisions to the Office of Inspector General's Civil Monetary Penalty Rules*, 79 *Federal Register* 27,080 (May 12, 2014) (the Proposed Rule). AHCA is the nation's leading long term care organization. AHCA and our membership of 11,000 non-profit and proprietary facilities are dedicated to continuous improvement in the delivery of professional and compassionate care provided daily by millions of caring employees to more than 1.5 million of our nation's frail, elderly and disabled citizens who live in nursing facilities, assisted living residences, subacute centers and homes for persons with mental retardation and developmental disabilities.

As you know, the Affordable Care Act (ACA) expanded the Department of Health and Human Services, Office of Inspector General's (OIG) authority to impose civil monetary penalties (CMP) and allowed for significant new penalties. In the Proposed Rule, the OIG incorporates the statutory changes enacted by the ACA and reorganizes and clarifies the current CMP regulations that the agency deems "cumbersome"<sup>1</sup> and "confusing."<sup>2</sup>

Below we elaborate upon AHCA's recommended modifications to the Proposed Rule. In sum, AHCA urges the OIG to:

<sup>1</sup> 79 Fed. Reg. 27,080, 27,081-82 (May 12, 2014).

<sup>2</sup> *Id.* at 27,082.

- Ensure that the Centers for Medicare & Medicaid Services (CMS) clarifies the definition of “identification” of an overpayment in advance of implementing regulations that would impose a \$10,000 per day penalty for not timely reporting and returning an identified overpayment;
- Guarantee a minimum amount of time for providers to respond to a record request from the OIG before a CMP may be imposed for failing to timely grant access to requested records; and
- Adopt an “alternate methodology” for calculating penalties and assessments for employing or engaging excluded individuals who do not directly bill the federal health care programs for furnishing items or services that reflects a provider’s payor mix.

### **Overpayments**

As you know, Section 6402(a) of the ACA amended the Social Security Act to add various program integrity provisions, including a section that addresses the “Reporting and Returning of Overpayments.”<sup>3</sup> Pursuant to that section, a person who receives an overpayment must report and return the overpayment to CMS, the state, an intermediary, a carrier, or a Medicare Administrative Contractor (MAC), as appropriate.

Section 6402(a) of the ACA also established the deadline for reporting and returning overpayments as the later of 60 days after *identification* of the overpayment or by the date that the corresponding cost report is due (as applicable). However, the ACA did not address how overpayments are identified or otherwise define “identification.” As you likely know, CMS proposed a definition of “identification” of an overpayment in a February 2012 proposed rule. To date, however, CMS has not finalized such definition through a final rulemaking.<sup>4</sup>

Without a definition of “identification,” as it relates to the ACA’s deadline for reporting and returning overpayments, the Proposed Rule would permit the OIG to impose a \$10,000 per day penalty for failing to report and return overpayments on a timely basis. However, because of the complexity of billing for some items and services, Medicare and Medicaid providers are, at times, faced with a difficult challenge in determining (or “identifying”) whether or not a particular claim caused an overpayment. Without further clarification regarding when an identification of an overpayment occurs, the Proposed Rule would unfairly impose a significant monetary penalty on a *per day* basis. Notably, it currently remains undefined when the “identification” of an overpayment occurs, and as a consequence, in certain situations it could be unclear when a provider has passed 60 days after such “identification,” a date which would potentially trigger a \$10,000 *per day* penalty. The potential imposition of a penalty, on a per day basis, when it is not clear when the commencement of such penalty would begin could lead to indeterminate penalty amounts and provide the OIG with inappropriate discretion to determine such penalty amounts.

Furthermore, clarification regarding when an identification of an overpayment occurs is particularly important to AHCA’s members because of the potential False Claims Act (FCA) liability for failure to timely report and return overpayments. Accordingly, AHCA recommends that OIG to defer issuance of any final rule imposing a CMP for failure to timely report and return overpayments until CMS finalizes its related rulemaking.

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<sup>3</sup> 42 U.S.C. § 1320a-7k(d)(2).

<sup>4</sup> 77 Fed. Reg. 9179 (Feb. 16, 2012).

## **Access to Records**

AHCA is concerned that nothing in the Proposed Rule guarantees a responding party a minimum amount of time in which to grant timely access of records to the OIG. As authorized under the ACA, the Proposed Rule adds a penalty not to exceed \$15,000 per day for a provider who fails to grant timely access to records, upon a reasonable request, to the OIG for the purpose of audits, investigations, evaluations or other statutory functions. The Proposed Rule also would give the OIG wide latitude to specify the date on which a responding party must provide access to requested materials. The OIG defines the term “reasonable request” as “a written request, signed by a designated representative of the OIG and made by a properly identified agent of the OIG during reasonable business hours” and would include, among other details, the OIG-imposed deadline for access to its requests. In the preamble to the Proposed Rule, the OIG indicates that in setting such deadline it would consider the circumstances of the request, including the volume of material, size and capabilities of the party subject to the request, and the OIG’s need for the material in a timely way to fulfill its responsibilities. However, nothing in the Proposed Rule guarantees a responding party a minimum amount of time in which to provide a response to the OIG. AHCA urges the OIG to ensure providers are universally granted a minimum amount of time to respond to such requests before the OIG may impose a CMP.

## **False Statements**

AHCA believes that the OIG inappropriately broadens its authority under the ACA to impose a penalty not to exceed \$50,000 for each “omission” of a material fact in any application, bid or contract to participate or enroll as a provider under a federal health care program. While the ACA authorized penalties for false statements and misrepresentations of material fact, the law did not include the word “omission” in describing the penalty. The OIG’s assertion in the preamble simply stating that including the word “omission” is necessary “to give full effect to the amendment,” is outside the statutory requirement.

## **Penalties for Employing Excluded Individuals**

While AHCA applauds the OIG for proposing an “alternate methodology” for calculating penalties and assessments for employing or contracting with excluded individuals who do not directly bill the federal health care programs for furnishing items or services, the OIG’s proposal does not properly account for a provider’s payor mix. In fact, the OIG’s proposed “alternate methodology” differs from the methodology the OIG has used informally – and the methodology that the agency articulates in its 2013 *Updated Provider Self-Disclosure Protocol* (SDP)<sup>5</sup> – because it does not take into account the pro rata amount of federal health care problem billings.

The Social Security Act currently permits penalties for arranging or contracting with an individual or entity excluded from a federal health care program for the provision of items or services which may be paid by a federal health care program. In the Proposed Rule, the OIG restates its broad view that “the provision of items or services” includes every person or entity involved in any way in the furnishing of the item or services that are billed to the federal health care program. The OIG recognizes, however, that individuals and entities may be involved in the provision of items and services in a variety of ways, and thus delineates between: 1) the

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<sup>5</sup> OIG, OIG’s Provider Self-Disclosure Protocol (Apr. 17, 2013), <http://oig.hhs.gov/compliance/self-disclosure-info/files/Provider-Self-Disclosure-Protocol.pdf>.

furnishing, providing, ordering or prescribing of separately billable items or services; and 2) the provision of items or services included as a component of a separately billable item or service.

For items and services that are separately billable, the Proposed Rule would permit the OIG to impose a penalty of not more than \$10,000 for each separately billable item or service provided, furnished, ordered or prescribed by an excluded individual, plus an assessment of not more than three times the amounts billed for such items or series. This is the same methodology currently employed by the OIG. For excluded persons where the items and services are not separately billable, however, the OIG would determine a penalty based upon the number of days the person was employed or contracted with the provider, and assessments would be based upon the workers total compensation, including salary, benefits and other money or items of value. The OIG contends that this framework “would achieve the purposes of section 1128(a)(6) of the Act by penalizing the act of employing or otherwise contracting with the excluded person in proportion to the number of days the prohibited relationship with excluded person existed.”<sup>6</sup>

The OIG’s Proposed Rule is slightly different than what it articulates in its 2013 SDP because it does not take into account the pro rata amount of federal health care program billings. Specifically, under the OIG’s proposal, the total amount of the excluded person’s compensation would have to be repaid, even if a portion of his or her time was not involved in federal health care program items or services. AHCA strongly urges the OIG to correct the disparity the Proposed Rule would create if implemented and instead implement a final rule that would properly account for a provider’s payor mix.

On behalf of our members, AHCA thanks you for the opportunity to submit these comments.

Sincerely,

A handwritten signature in black ink, appearing to read "Mike Cheek". The signature is fluid and cursive, with a long horizontal stroke at the end.

Mike Cheek  
AHCA, Sr. V.P., Finance Policy & Legal Affairs

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<sup>6</sup> 79 Fed. Reg. 27,080, 27,085 (May 12, 2014).