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April 16, 2012

Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-6037-P
Room 445—G
Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, DC 20201

Re: Proposed Rule, Medicare Program; Reporting and Returning of Overpayments, 77 Federal Register 9179, February 16, 2012, CMS-6037-P

Dear Ms. Tavenner:

The American Health Care Association ("AHCA") appreciates the opportunity to comment on the proposed rule, *Reporting and Returning of Overpayments*, 77 Federal Register 9179, February 16, 2012, CMS-6037-P (the "Proposed Rule").

AHCA is the nation's largest association representing long term and post-acute care providers. Our 11,000 members include profit and not-for-profit skilled nursing facilities, assisted living residences, subacute centers, and homes for persons with mental retardation and developmental disabilities. Our members are dedicated to continuous improvement in the delivery of professional and compassionate care provided daily to more than 1.5 million of our nation's frail, elderly, and disabled citizens.

After a thorough review of the Proposed Rule, AHCA has developed several recommendations that the Centers for Medicare & Medicaid Services ("CMS") should carefully consider as it promulgates the final rule related to the reporting and returning of overpayments. We believe that our suggestions align with Section 6402(a) of the Patient Protection and Affordable Care Act ("ACA"), and CMS' goal of protecting the Medicare Trust Funds against fraud and improper payments. In addition, our recommendations support both CMS' and AHCA's ongoing efforts to assure the promotion of high quality care.

In the Executive Summary Section, directly below, we highlight several concerns related to the Proposed Rule and our recommendations to mitigate or alleviate those concerns. In the Discussion section below we elaborate upon each of our concerns and corresponding proposals to allay each respective concern.

Lastly, we reiterate again that we support CMS' efforts to protect Medicare and Medicaid and again express our appreciation to CMS for working with stakeholders to date in many areas to effectively implement various ACA provisions. We hope to work with CMS in this area and stand ready to assist you in developing appropriate policies impacting the long-term care industry.

I. EXECUTIVE SUMMARY

AHCA recognizes and understands Congress' and CMS' desire and interest in ensuring that overpayments are returned to the Medicare Trust Funds in a timely manner. AHCA also appreciates and supports CMS' efforts to combat fraud, abuse, and other waste in the Medicare program.

However, with this Proposed Rule, CMS further expands the already burdensome web of reporting requirements providers and suppliers face today. In addition, the Proposed Rule escalates the complexity of various, inconsistent time periods providers have to retain records and report situations that could be considered an "overpayment"; creates duplicative reporting obligations and processes; and further muddles how a Medicare provider or supplier is to proceed when faced with a situation that could be an overpayment.

The heightened complexity and worsening burdens providers and suppliers face punishes long term care and other post-acute providers that operate with integrity and undermines CMS' fight against fraud, abuse, and other waste. In order to most effectively accomplish its goal of ensuring that overpayments are returned to the Medicare Trust Funds in a timely manner, CMS should modify the Proposed Rule to strike a balance between its concerns and the reality of the enormously burdensome nature of its proposals.

Specifically, AHCA recommends:

1. CMS should adopt a three year lookback period in lieu of the proposed ten year lookback period;

2. The SRDP and the SDP should both fulfill the reporting obligations under Section 6402(a) and the final overpayment rule;

3. Reporting and repayment obligations should only be imposed where the "overpayment" cannot be addressed in the normal course of business;

4. CMS should confirm that a provider or supplier does not "identify" an overpayment until it has determined all of the information required by CMS, including the amount of the overpayment;

5. CMS should add exceptions for the reconciliation process to reflect: (1) the results of Recovery Audit Contractors("RAC") and Zone Program Integrity Contractor ("ZPIC") audits; and (2) participation in voluntary pre-enforcement processes such as SRDP and OIG SDP, as applicable

6. CMS should develop the uniform reporting form prior to finalizing the overpayment rule, and it should address the concerns related to the current MAC voluntary refund process forms, such as the inability for a reporting provider or supplier to submit multiple, related overpayments at once;

7. CMS should suspend the overpayment reporting and repayment requirements in various situations, including when a provider utilizes the claims correction process or quarterly credit balance reporting process, among other adjustment requests and applicable contractor processes;

8. CMS should develop a materiality threshold or a de minimis standard under which providers and suppliers will not be responsible for reporting and repaying overpayments under that threshold or standard and will not face any liability for not reporting and repaying such overpayments; and

9. CMS should re-evaluate its cost calculations in the Proposed Rule's Collection of Information Requirements Section.

Again, we believe these recommendations align with Section 6402(a) of the ACA, and CMS' goal of protecting the Medicare Trust Funds against fraud and improper payments. Lastly, we reiterate that we stand ready to assist you in developing appropriate policies impacting the long-term care industry.

II. OVERVIEW OF SECTION 6402(A)

Section 6402(a) of the ACA includes the overpayment provision, which has been codified at 42 U.S.C. § 1320a–7k(d) (hereinafter called "Section 6402(a)"). Section 6402(a) states that if a person has received an overpayment, the person must "report and return the overpayment to the Secretary, the State, an intermediary, a carrier, or a contractor, as appropriate, at the correct address; and notify the Secretary, State, intermediary, carrier, or contractor to whom the overpayment was returned in writing of the reason for the overpayment."[1] The statute then sets forth a deadline for the reporting and repaying of overpayments, specifically stating, "[a]n overpayment must be reported and returned . . . by the later of the date which is 60 days after the date on which the overpayment was identified; or the date any corresponding cost report is due, if applicable."[2]

Section 6402(a) also codifies certain definitions related to the overpayment provision, including "knowing and knowingly," which have the same definitions as under the federal False Claims Act ("FCA").[3] In addition, the statute defines overpayment as "any funds that a person receives or retains under subchapter XVIII or XIX of this chapter to which the person, after applicable reconciliation, is not entitled under such subchapter."[4] Finally, Section 6402(a) defines "person" to include "a provider of services, supplier, Medicaid managed care organization [as defined by statute], Medicare Advantage organization [as defined by statute], or PDP sponsor [as defined by statute]," but excluding beneficiaries.[5]

Importantly, Section 6402 explicitly raises the stakes for providers who fail to timely meet the reporting and repayment requirements. First, if a provider or supplier retains an overpayment past the reporting and repayment deadline set forth in Section 6402(a), the retained overpayment becomes an "obligation" as defined by the FCA, 31 U.S.C. § 3729(b)(3).[6] Second, Section

[1] 42 U.S.C. § 1320a–7k(d)(1).

[2] 42 U.S.C. § 1320a–7k(d)(2).

[3][3]42 U.S.C. § 1320a–7k(d)(4)(A); 31 U.S.C. § 3729(b) defines the terms "knowing" and "knowingly":

> (A) mean that a person, with respect to information--
>
> > (i) has actual knowledge of the information;
> >
> > (ii) acts in deliberate ignorance of the truth or falsity of the information; or
> >
> > (iii) acts in reckless disregard of the truth or falsity of the information; and
>
> (B) require no proof of specific intent to defraud . . . .

Note that "knowing" and "knowingly" are not used anywhere the statutory language of 6402(a) **except** the "definitions" section. The inclusion of these definitions is likely a drafting error.

[4] 42 U.S.C. § 1320a–7k(d)(4)(B).

[5] 42 U.S.C. § 1320a–7k(d)(4)(C).

[6] *See* 42 U.S.C. § 1320a–7k(d)(3); 31 U.S.C. § 3729(b)(3) states:

6402(d)(2) of the ACA amends the federal civil money penalty ("CMP") statute to allow for the imposition of penalties on any person that "knows of an overpayment (as defined in paragraph (4) of [42 U.S.C. § 1320a–7k(d)] and does not report and return the overpayment in accordance with such section."[7]

The possible implications of providers and suppliers not appropriately reporting and returning an overpayment as required by Section 6402(a) are considerable and heighten the importance of both compliance with Section 6402(a) and the final regulations that CMS will promulgate to provide guidance to providers and suppliers. This significant, potential liability makes it critical that CMS carefully consider the comments and suggestions submitted by providers and suppliers as it makes revisions to the Proposed Rule.

Section 6402(a) can be summarized as containing four components: (1) a general requirement to report and repay overpayments; (2) a deadline for reporting overpayments; (3) an enforcement provision explaining that the retention of an overpayment after the statutory deadline creates an obligation under the federal False Claims Act; and (4) a definitions section. The statute was effective upon enactment of the ACA, March 23, 2010. Notably, nothing in the statute indicates that Section 6402(a) is to be applied retroactively. The statutory language does not set forth a lookback period or even suggest a lookback period.

III. DISCUSSION

A. Proposed Ten Year Lookback Period

1. Overview

In the Proposed Rule, CMS advises that overpayments must be reported and returned if identified within ten years of the date the provider or supplier received the overpayment. In addition, CMS proposes to amend the reopening rules at 42 C.F.R. § 405.980(b) to allow contractors ten years to reopen initial determinations and redeterminations for overpayments reported in response to 42 C.F.R. § 405 (the "Overpayment Rule").

AHCA has grave concerns regarding the proposed ten year lookback period. First, we believe that CMS' suggestion to use the "outer limit of the False Claims Act statute of limitations"[8] is inappropriate because the statutory language does nothing to suggest this time period; it improperly associates simple overpayments to the False Claims Act; and it is inconsistent with various Medicare and Medicaid regulations and guidance and even with the language of the False Claims Act itself.

Adopting a ten year lookback period would require providers and suppliers to retain records for ten years and necessitate review of an enormous number of records produced by a provider or supplier within a ten year period. In addition, providers and suppliers would be compelled to check for any discrepancies contained in ten years of records in an attempt to identify any potential overpayments. After the identification of possible overpayments, a provider or supplier would be forced to extensively research and quantify the overpayment, potentially under intense time pressure.

The record retention, reviews, and subsequent research of potential overpayments would likely create an extraordinary operational, administrative, and financial burden on providers. The time, money, and personnel resources demanded by the proposed ten year lookback period would be

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> the term "obligation" means an established duty, whether or not fixed, arising from an express or implied contractual, grantor-grantee, or licensor-licensee relationship, from a fee-based or similar relationship, from statute or regulation, or from the retention of any overpayment . . . .

[7] 42 U.S.C. § 1320a-7a.

[8] 77 Fed. Reg. 9179, 9184 (Feb. 16, 2012).

exceedingly burdensome to skilled nursing facilities ("SNFs") and other long term and post-acute care providers.

Below, we fully explain our concerns and provide a recommended substitute lookback period which conforms to current Medicare law.

2. Section 6402's Statutory Language Does Not Contain a Ten Year Lookback Period

As noted in Section II above, Section 6402(a)'s statutory language does not set forth a ten year lookback period. The idea of a lookback period is not even mentioned by Section 6402(a)'s language. Not only does Section 6402's text omit any mention of a lookback period or a suitable time frame for that lookback period, there is absolutely nothing in the text that suggests that the "outer limit of the False Claims Act statute of limitations"[9] would be the appropriate time window to impose as a lookback period.

While the statute does adopt the definitions of "knowing" and "knowingly" under the federal False Claims Act (though these defined terms are not included in the active statutory language) and includes enforcement language that makes an overpayment retained past 6402(a)'s deadline an "obligation" under the federal FCA, the statute in no way insinuates that the "outer limit" of the FCA's statute of limitations would be an appropriate lookback period under the reporting and repayment requirements created by it.

CMS' proposed imposition of a ten year lookback period does not conform with the statutory language because Section 6402(a)'s language contains no such lookback period nor does it hint at such an expansive lookback period. Further, there is nothing in the legislative history that indicates that Congress intended for CMS to adopt such a lookback period.

3. Using FCA Statute of Limitations Inappropriately Links the Overpayment Rule to the FCA

Congress originally enacted the FCA in an attempt to reduce intentional fraud committed against the government. While the FCA imposes liability for a variety of acts, including, "knowingly present[ing], or caus[ing] to be presented, a false or fraudulent claim for payment or approval"[10] and "knowingly mak[ing], us[ing], or caus[ing] to be made or used, a false record or statement material to a false or fraudulent claim,"[11] the use of the FCA's "outer limit . . . statute of limitations" inappropriately associates overpayments with the FCA.

An overpayment and the identification of an overpayment do not inherently implicate the acts giving rise to liability under the FCA. Specifically, under the Proposed Rule an "overpayment" in a SNF could be the result of an inadvertent clerical error or a patient having switched to a managed care organization without the provider knowing. In the aforementioned, examples of "overpayments," and in the many, various other situations that may be deemed an "overpayment" under the Proposed Rule, the provider would not have the requisite intent needed for a FCA cause of action.

While the retention of an overpayment past the sixty day deadline imposed by Section 6402(a) creates an "obligation" under the FCA, without the requisite intent, this retention does not give rise to liability under the FCA. The FCA states that "knowingly mak[ing], us[ing], or caus[ing] to be made or used, a false record or statement material to an **obligation** to pay or transmit money or property to the Government, or knowingly conceal[ing] or knowingly and improperly

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[9] 77 Fed. Reg _9179, 9184 (Feb. 16, 2012).
[10] 31 U.S.C. § 3729(a)(1)(A).
[11] 31 U.S.C. § 3729(a)(1)(B).

avoid[ing] or decreas[ing] an **obligation** to pay or transmit money or property to the Government" triggers liability under the FCA.[12] Thus, imposing any FCA time frame as a lookback period under the Overpayment Rule improperly connects the Overpayment Rule to the FCA and would result in a burdensome shift in policy.

If CMS' concern is fraud against the Medicare program, then Medicare contractors already have a mechanism to reopen determinations or redeterminations, **at any time**, where "reliable evidence" exists that "the initial determination was procured by fraud or similar fault."[13] Since the Medicare reopening regulations already permit contractors to reopen determinations or redeterminations at any time if the determination was obtained by fraud, it is unnecessary to include such an expansive lookback period in the Overpayment Rule.

4. The Ten Year Lookback Period is Inconsistent with Current Medicare Regulations and Guidance

The ten year lookback period proposed by CMS is inconsistent with current Medicare regulations, including the reopening regulations, other lookback periods developed by CMS, and Medicare record retention requirements. If CMS adopts a ten year lookback period, providers and suppliers would be forced to adopt corresponding record retention policies. As noted above, retaining records for ten years and the reviewing thousands if not millions of records produced within a ten year period, checking any discrepancies contained in those records and identifying and researching any potential overpayments, and reporting and returning any identified overpayments under intense time pressure would create an overwhelming burden to all providers and suppliers.

a. The Ten Year Lookback Period is Contrary to the Medicare Reopening Regulations and Other Lookback Periods Developed by CMS

The Medicare reopening regulations and corresponding related to initial (claim) determinations permit a "contractor" to have a one-year reopening period "for any reason" or a four-year reopening period "for good cause."[14] CMS' suggested adoption of a ten year look back period, and the Proposed Rule's corresponding amendment to the Medicare claim determination reopening regulations, significantly diverges from the current time periods set forth in the reopening regulations, which allow for a four-year reopening period only "for good cause."

In addition, the ten year lookback period contrasts with the Medicare reopening regulations and guidance related to the reopening of an intermediary determination or a reviewing entity decision, which includes the reopening of cost reports. The Medicare reopening regulations for intermediary determinations and reviewing entity decisions sets forth a three year reopening window.[15] Notably, the Proposed Rule does not contain an extension of this reopening time period, as discussed further in Section III.A.9 below.

Interestingly, the ten year reopening period is also contrary to lookback periods developed by CMS in relation to other Medicare programs. For example, in the Statement of Work published by CMS in relation to the Recovery Audit Contractor ("RAC") program CMS states:

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[12] 31 U.S.C. § 3729(a)(1)(G) (emphasis added).

[13] 42 C.F.R. § 405.980(b)(3).

[14] 42 C.F.R. § 405.980(b). In addition, 42 C.F.R. § 405.980(b)(3) states that reopening can be initiated at any time "if there exists reasonable evidence . . . that the initial determination was procured by fraud or similar fault."

[15] *See* 42 C.F.R. § 405.1885(b); Provider Reimbursement Manual, CMS Pub. 15-1, Chapter 29, § 2931.1; note that 42 C.F.R. § 1885(b)(3) allows for reopenings for an indeterminate amount of time "if it is established that the determination or decision was procured by fraud or similar fault."

> The Recovery Auditor shall not attempt to identify any overpayment or underpayment **more than 3 years past** the date of the initial determination made on the claim. The initial determination date is defined as the claim paid date. **Any overpayment or underpayment inadvertently identified by the Recovery Auditor after this timeframe shall be set aside**.[16]

Further, in a slide presentation developed by CMS explaining the Recovery Audit Program, CMS asserts that one of the "three keys to success" of the Recovery Audit Program is to "minimize provider burden" by "limit[ing] the RAC 'look back period' to three years."[17] Again, CMS' proposed ten year lookback period directly contradicts the three year lookback period established by CMS in the Recovery Audit Program and contravenes the rationale articulated by CMS for instituting the RAC three year lookback period, namely "minimiz[ing] provider burden."[18]

b. The Ten Year Lookback Period is at Odds with the Medicare and Medicaid Record Retention Requirements

In addition to conflicting with CMS regulations related to reopening periods and prior guidance issued by CMS with respect to the RAC program, the Proposed Rule conflicts with both Medicare and Medicaid record retention requirements. Setting forth a ten year lookback period in the final Overpayment Rule would ostensibly require providers and suppliers to retain records for a ten year period. The ten year lookback period and the resulting ten year record retention requirements are incompatible with the current Medicare and Medicaid record retention requirements, as discussed further below, and, if finalized, would enormously expand the already hefty administrative and financial burdens associated with record retention.

First, record retention requirements vary by state, provider type, and state regulatory agency issuing the record retention requirements for particular provider types. However, Medicare regulations only require nursing homes to retain medical records for five years if state law does not prescribe a specific record retention requirement.[19] Medicaid record retention requirements are determined by states, and differ on a state-by-state basis.

Second, many providers and suppliers include a "books and records" provision in contracts executed by and between a provider or supplier and a subcontractor. This "books and records" provision is based upon Section 952 of the Omnibus Reconciliation Act of 1980, codified at 42 U.S.C. § 1395x(v)(I). This provision states:

> [U]ntil the expiration of **four years** after the furnishing of such services pursuant to such contract, the subcontractor shall make available, upon written request by the Secretary, or upon request by the Comptroller General, or any of their duly authorized representatives, the contract, and books, documents and records of such subcontractor that are necessary to certify the nature and extent of such costs . . . .[20]

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[16] *See* Statement of Work for the Recovery Audit Program, Centers for Medicare & Medicaid Services (Sept. 1, 2011), *available at* http://www.cms.hhs.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/recovery-audit-program/index.html?redirect=/RAC/.

[17] *See* Recover Audit Program Slide Presentation, Centers for Medicare & Medicaid Services, *available at* http://www.cms.hhs.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/recovery-audit-program/index.html?redirect=/RAC/.

[18] *Id.*

[19] *See* 42 C.F.R. § 483.75(l)(2)(ii).

[20] 42 U.S.C. § 1395x(v)(I)(ii).

Because 42 U.S.C. § 1395x(v)(I) establishes a four year record retention period, many contracts by and between providers and suppliers and subcontractors explicitly include a four year record retention requirement. Again, the proposed ten year lookback period directly contradicts with this language codified at codified at 42 U.S.C. § 1395x(v)(I) and included in many contracts involving providers and suppliers and their subcontractors.

Third, HIPAA requires that covered entities, including providers and suppliers, retain "required documentation," meaning policies and procedures related to HIPAA, for six years.[21] While the HIPAA regulations do not require providers and suppliers to retain medical records for a specific time period, they do require that covered entities apply the necessary privacy safeguards to records containing protected health information and maintain and dispose of such records in a HIPAA-compliant fashion.[22]

Providers and suppliers have adopted record retention policies that reflect the aforementioned Medicare, Medicaid, and HIPAA record retention requirements. In addition, this lookback period does not account for the currently evolving state of providers' and suppliers' record-keeping. At this point, many providers and suppliers use a blended or "hybrid" record-keeping approach, utilizing both paper and electronic records as they transition to electronic health records ("EHR"). Some providers and suppliers have or will changed to new EHR systems that do not support previous EHR applications, and the cost of maintaining licensure for duplicate EHR applications may be cost-prohibitive. Implementing a ten year lookback period will only exacerbate the record retention-related financial and administrative strains faced by providers and suppliers as their record-keeping advances.

The Proposed Rule's ten year lookback period—which is inconsistent with the aforementioned record retention requirements— would impose a significant, further burden with respect to record retention. This burden would prompt considerable, additional costs for SNFs and other long term and post-acute care providers.

5. **The Ten Year Lookback Period Longer than Statute of Limitations Period for the Civil Money Penalties Liability**

The ten year lookback period also exceeds the statute of limitations period for the Civil Money Penalties Law ("CMPL"). The CMPL explicitly states, "[t]he Secretary may not initiate an action under this section with respect to any claim, request for payment, or other occurrence described in this section later than **six years** after the date the claim was presented, the request for payment was made, or the occurrence took place."[23] It is difficult to discern why the lookback period with respect to Section 6402(a) should so dramatically surpass the statute of limitations under the CMPL.

6. **The Ten Year Lookback is Inconsistent with Language of the False Claims Act**

In the Proposed Rule's preamble, CMS concedes that ten years is the "outer limit of the False Claims Act statute of limitations."[24] In fact, the actual language of the FCA seems to be more narrowly drawn, limiting an FCA cause of action to no more than six years after a violation of the

[21] *See* 45 C.F.R. § 164.316(b)(2).
[22] *See* 45 C.F.R. 164.530(c).
[23] 42 U.S.C. § 1320a-7a(c)(1).
[24] 77 Fed. Reg. 9179, 9184 (Feb. 16, 2012).

FCA is committed *or* no more than three years after the government knows or should have known facts material of the right of action.[25] Specifically, 31 U.S.C. § 3731(b) states:

> A civil action under [the False Claims Act] may not be brought--
>
> > (1) **more than 6 years** after the date on which the violation of [the False Claims Act] is committed, or
> > (2) **more than 3 years after the date when facts material to the right of action are known or reasonably should have been known by the official of the United States charged with responsibility to act in the circumstances, but in no event more than 10 years after the date on which the violation is committed, whichever occurs last**.

The False Claims Act provision, quoted above, includes a second statute of limitations[26] that caps the time period when a civil action may be brought by the United States under the FCA. This second, ten year cap generally only applies to FCA claims where the government belatedly discovers facts related to the cause of action. Given the limited circumstances to which this "outer limit" is applied, it is not appropriate to incorporate the ten year "outer limit" as a lookback period in the context of overpayments.

7. Potential Retroactivity Concerns Related to the Ten Year Lookback Period

The ten year lookback period raises questions regarding the possibility of CMS' enforcement of the Overpayment Rule. If CMS retroactively applies the Overpayment Rule, it could result in an "impermissible retroactive effect." The ACA is not retroactive by its terms and CMS has not been granted retroactive rulemaking authority by Congress with respect to the Overpayment Rule. Therefore, it seems clear that CMS should not apply the final Overpayment Rule to any overpayments that occurred or were identified before the date of enactment of the ACA, March 23, 2010. A contrary interpretation would conflict with existing case law[27] and with Medicare's "without fault" rules.[28] Such retroactive application would violate the "settled expectations" test for permissible retroactivity.

While the Proposed Rule is silent regarding the retroactive application of the Overpayment Rule, retroactive application of the ten year lookback period would likely raise retroactive enforcement concerns and could result in numerous lawsuits challenging CMS' retroactive application of the Overpayment Rule.

8. The Proposed Rule Does Not Give Providers a Parallel Ten Year Reopening Period

The Proposed Rule would allow CMS to impose a ten year lookback period for the identification of overpayments, but providers would be stuck in the current reopening framework, disallowing a

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[25] 31 U.S.C. § 3731(b).

[26] This is sometimes referred to as a statute of repose.

[27] In *U.S. ex rel. Stone v. OmniCare, Inc.* (N.D. Ill. July 7, 2011) 2011 WL 2669659, at *2-*4 (finding that such a theory would create "impermissible retroactive effect" and that because the ACA is silent regarding retroactivity, identification of the overpayment must occur after the passage of the ACA for the report and return provision to apply).

[28] *See, e.g.*, 42 U.S.C. § 1395gg(c) and 42 C.F.R. §405.350(c) (absent evidence to the contrary, recipients of Medicare payments are considered without fault if applicable payor determines amount was incorrect after the third year in which payment was made). Payments subject to these rules arguably may not constitute overpayments at all because by virtue of the without fault rules, such payments may not constitute amounts to which the provider is "not entitled."

parallel time period to identify underpayments and dispute overpayment corrections demanded by a contractor or CMS. While the Proposed Rule amends 42 C.F.R. § 405.980(b), and would provide that overpayments related to initial determinations and redeterminations reported in accordance with the Overpayment Rule may be reopened for a period of ten years, this provision of the reopening regulations applies only to the time frames for reopening initial determinations and redeterminations initiated by a contractor—not to the reopening time frames applicable to providers and suppliers.

Under the current Medicare reopening regulations at 42 C.F.R. § 405.980(c), a "party" is permitted a one-year reopening period of an initial (claim) determination or redetermination "for any reason" or a four-year reopening period "for good cause."[29] As defined in 42 C.F.R. § 405.902, a party means "[a Medicare beneficiary, a supplier, or a provider] that has standing to appeal an initial determination and/or a subsequent administrative appeal determination."[30]

Further, the current Medicare reopening regulations related to intermediary determinations and reviewing entity decisions, such as cost reports, allow for such determinations and decisions to be reopened for three years.[31] The expansion of the time period a contractor is permitted to reopen an initial determination or a redetermination without the expansion of the time period a provider or supplier can reopen an initial determination or redetermination, or an intermediary determination or reviewing entity decision, creates an inequitable result, giving CMS and contractors an advantage over providers.

In addition, without a parallel time period under which providers and suppliers may identify underpayments and dispute overpayment corrections demanded by a contractor or CMS, a Medicare beneficiary could receive services or goods, but a provider or supplier may not receive Medicare payment.

For example, in the context of SNFs, if a SNF bills Medicare for the incorrect Resource Utilization Group ("RUG"), and this mistake is identified seven years later, CMS would cancel the claim that includes the incorrect RUG and demand a full repayment, but the SNF would not receive payment under the correctly billed RUG. If the SNF discovers that it billed Medicare for the incorrect RUG within a year, the corrected claim may be resubmitted, and the SNF would be paid. However, if this error was found outside of the permissible billing window of a year, the claim will be canceled, CMS would demand a full repayment, and the SNF cannot resubmit the claim and subsequently cannot be reimbursed by Medicare. Consequently, the Medicare beneficiary would have received SNF care, but the SNF would not receive payment for its care.

While the aforementioned result can already occur within the Medicare billing structure, the expansive lookback period could increase the number of situations where a provider or supplier would furnish goods or services, but then would identify an overpayment outside of the time period where it can resubmit a bill under the current billing structure. The provider or supplier then would be unable to resubmit a bill and would not receive payment for the goods and services it furnished.

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[29] 42 C.F.R. § 405.980(c). In addition, 42 C.F.R. § 405.980(c) states that "a party may request that a contractor reopen its initial determination at any time if the initial determination is unfavorable, in whole or in part, to the party thereto, but only for the purpose of correcting a clerical error on which that determination was based."

[30] *See* 42 C.F.R. § 405.902; 42 C.F.R. § 405.902

[31] *See* 42 C.F.R. § 405.1885(b); Provider Reimbursement Manual, CMS Pub. 15-1,Chapter 29, § 2931.1; note that 42 C.F.R. § 1885(b)(3) allows for reopenings for an indeterminate amount of time "if it is established that the determination or decision was procured by fraud or similar fault."

9. Financial, Administrative, and Time Costs of Ten Year Lookback Period to Providers and Suppliers

The Proposed Rule's Collection of Information Requirements section states:

> For purposes of this section only, we estimate that approximately 125,000 providers and suppliers (or roughly 8.5 percent of the total number of Medicare providers and suppliers) would report and return overpayments in a typical year under our proposed provisions. In addition, we project that each of these providers and suppliers would, on average, separately report and return approximately 3 to 5 overpayments. We also estimate that it would take a provider or supplier approximately 2.5 hours to complete the applicable reporting form and return an overpayment. . . . This, in turn, leads to an aggregate annual ICR burden cost, attributable to the impacted 125,000 providers and suppliers for the range of 3 to 5 overpayments, of $34.78 million and $57.97 million, respectively.[32]

Using the average hourly rate of staff that would be responsible for reporting and returning overpayments estimated by CMS, $37.10, which includes fringe benefits and overhead, the reporting and returning of an overpayment would cost approximately $92.75.

CMS dramatically underestimates the cost of the Proposed Rule to providers and suppliers. For example, CMS does not include in its Collection of Information Requirements any cost calculations related to the added costs of retaining records for a ten year period, which is longer than many providers and suppliers currently retain records, or reviewing additional years of records for potential overpayments. Again, the financial and administrative burden of retaining records for ten years is great, and being responsible for reviewing such a lengthy period of time for possible overpayments would require significant time, money, and manpower. In laying out the estimates costs of the Proposed Rule to providers and suppliers, CMS neglects to consider the costs of retaining and reviewing records for an additional period of time.

10. Recommendation: CMS Should Adopt a Three Year Lookback Period

In the Proposed Rule's preamble, CMS states that it believes the ten year lookback period is appropriate for several reasons, including that "providers and suppliers should have certainty after a **reasonable** period that they can close their books and not have ongoing liability associated with an overpayment."[33] CMS also asserts that it believes a ten year lookback period "is long enough to sufficiently further our interest in ensuring that overpayments are **timely** returned to the Medicare Trust Funds."[34]

AHCA agrees that providers and suppliers should have certainty that after a **reasonable** period they can close their books and CMS' interest in ensuring that overpayments are **timely** returned to the Medicare Trust Funds should be fulfilled. However, a ten year lookback period is not reasonable, as it would be very taxing to providers and suppliers. And a ten year lookback period would not do anything to ensure the timely return of Medicare overpayments.

In lieu of a ten year lookback period, AHCA recommends that CMS adopt a three year lookback period in its final rule. This lookback period would align with the lookback period previously adopted by CMS with respect to the RAC program; would follow the three year period set forth in 42 C.F.R. § 405.1885, "reopening an intermediary determination or reviewing entity decision"

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[32] 77 Fed. Reg. 9179, 9184-85 (Feb. 16, 2012).
[33] *Id*. at 9184.
[34] *Id*.

and Section 2931.1 of the CMS Provider Reimbursement Manual;[35] and would allay the potential for a significantly increased burden on providers and suppliers.

B. The Definition of "Identified" and When the Sixty Day Clock Starts

1. Concerns Related to "Identified"

In the Proposed Rule, CMS states that "a person has identified an overpayment if the person has actual knowledge of the existence of the overpayment or acts in reckless disregard or deliberate ignorance of the existence of an overpayment." By adopting the above definition of "identified," CMS imports the definition of "knowing" and "knowingly" incorporated in Section 6402(a) by reference to the FCA.[36]

However, while Section 6402(a) defines both "knowing" and "knowingly," neither is used anywhere else in the text of Section 6402(a). In other words, the only use of "knowing" and "knowingly" in Section 6402(a) is in the definitions section. Defining a term that is not used in the actual statutory language is perplexing and inappropriate. In fact, the definitions of "knowing" and "knowingly" appear to be a drafting error. The House of Representatives' version of the legislation that became the ACA incorporated "knowing" and "knowingly" in the text of the overpayment reporting and repayment provisions **and** in the definitions section. In the version of ACA that was enacted, while "knowing" and "knowingly" were removed from the active text of the statute, they were still included in the definitions, indicating that the inclusion of these definitions is erroneous.

As a consequence, CMS' reliance on the FCA's definition of "knowing" and "knowingly" in the Proposed Rule is misplaced. CMS' use of the FCA knowledge standard would create uncertainty regarding whether or not contractors, CMS, and the courts would second-guess providers' and suppliers' efforts, and would place significant pressures on providers and suppliers to bolster their internal monitoring and reporting capabilities and conduct rapid investigations of any indication that there was a possible overpayment. In the Final Rule, CMS should not incorporate the FCA definition of "knowing" and "knowingly" into its definition of "identified," as the reference in the text of the statute appears to be merely a drafting error.

2. When the Sixty Day Clock Starts

In the Proposed Rule, CMS discusses allowing providers the opportunity to identify the full scope and nature of the overpayment liability, and seems to recognize that this can, in some instances, take time. AHCA requests that CMS confirm that the sixty day period does not begin, meaning that identification has not occurred, until the provider or supplier has determined the complete details of the overpayment, including the total amount of the refund and other, associated overpayments discovered during a larger-scale inquiry.

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[35] Provider Reimbursement Manual, CMS Pub. 15-1, Chapter 29, § 2931.1 states, "An intermediary's initial determination on the amount of program payment contained in a notice of amount of program reimbursement, which is otherwise final, may be reopened by the intermediary within 3 years of the date of such notice."

[36] 42 U.S.C. § 1320a–7k(d)(4)(A); 31 U.S.C. § 3729(b)(1).

C. Overlap with Overpayment Rule, CMS' Self-Referral Disclosure Protocol ("SRDP"), and OIG's Self-Disclosure Protocol ("SDP")

In the Proposed Rule, CMS suggests the suspension of the reporting and repayment obligation imposed on providers and suppliers under Section 6402(a) and the Overpayment Rule once the provider or supplier has notified the Department of Health and Human Services' Office of Inspector General ("OIG") of the identified overpayment through the OIG's Self-Disclosure Protocol ("SDP").[37] In addition, CMS proposes to suspend the repayment, but not the reporting obligation, when CMS acknowledges receipt of a disclosure made pursuant to the CMS self-referral disclosure protocol ("SRDP").[38] In the Proposed Rule, CMS states, "[b]ecause the SRDP only suspends the running of the 60-day deadline to return a physician self-referral-related overpayment, the provider or supplier would be obligated still to report the overpayment using the process that we are proposing in the [Overpayment Rule]."[39]

Requiring reporting to both the SRDP and to a Medicare contractor under the Overpayment Rule is duplicative and seemingly unnecessary. In addition, CMS does not articulate either a legal or policy rationale for the different treatment of the SDP and the SRDP. Submitting both the SDP and the SRDP requires extensive information, time, and effort on behalf of providers and suppliers and should suffice as a report and suspend the overpayment repayment obligations under Section 6402(a) and the Overpayment Rule.

AHCA recommends that both the SRDP and the SDP suspend the reporting and repayment obligations imposed by Section 6402(a) and the Overpayment Rule. A final rule that establishes duplicative reporting requirements under both the SRDP and the Overpayment Rule would impose an additional, unnecessary burden on providers and suppliers and could lead to confusing reporting requirements.

D. The Overpayment Rule's Overlap with the Claims Correction Process and Quarterly Credit Balance Reporting Process

1. Overview of Concerns Related to Overpayment Rule's Overlap with the Claims Correction Process and Quarterly Credit Balance Reporting Process

The Proposed Rule does not discuss whether providers and suppliers can use the existing claims correction processes for routine errors that can be addressed and resolved in the normal course of business or whether providers and suppliers must follow the overpayment reporting and repayment requirements set forth the Proposed Rule in any and all situations that might fall under Section 6402(a)'s definition of "overpayment." While it seems reasonable for a provider to notify a MAC if a material, non-routine error is identified, it also seems unreasonable for every "routine" error to be subject to the cumbersome notification process set forth in the Proposed Rule. Based on the guidance provided in the Proposed Rule, it is unclear if CMS plans to prohibit providers and suppliers from using the claims correction process within the one-year resubmission window or if CMS would require dual processes—requiring providers and suppliers to follow the Overpayment Rule's reporting and repayment obligations and the claims correction process or quarterly credit balance report process.

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[37] More information on the OIG's Self-Disclosure Protocol is available at http://oig.hhs.gov/compliance/self-disclosure-info/index.asp.
[38] More information on CMS' Self-Referral Disclosure Protocol is available at http://www.cms.hhs.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/Self_Referral_Disclosure_Protocol.html.
[39] 77 Fed. Reg. 9179, 9183 (Feb. 16, 2012).

As discussed below, AHCA requests that CMS clarify that providers should continue to use existing claims and cost reporting correction processes to address issues that arise in the normal course of business. The online claims correction process should be expanded to allow an increased correction look back period of up to three years allowing provides a less administratively burdensome process to refund overpayments.

2. Overview of the Current Claims Correction Process and Quarterly Credit Balance Reporting Process

Today, the primary mechanism to refund overpayments is through an online claims correction or by including the claim on the quarterly credit balance report submitted to the MAC.
The Medicare Claims Processing Manual outlines general guidelines and time frames for adjusting a Medicare Part A claim. Section 130.1 of the Medicare Claims Processing Manual states, "Adjustment requests are the most common mechanism for changing a previously accepted bill."[40] In general, an adjustment seeking additional Medicare payment(s) must be submitted within the timely billing standards, which is usually one year from the through date of the original claim. However, an adjustment that repays any kind of overpayment may be submitted as long as the claim is not administratively final.[41]

Chapter 6, Section 30.5.1 of the Medicare Claims Processing Manual specifies a 120-day rule for SNF Part A claims where the adjustment is the result of an "MDS Correction." These claims must be adjusted within 120 days of the through date on the original claim.[42] This is an exception to the general rule which allows claim correction for claims that are still within timely billing guidelines.

In practice, many Medicare administrative contractors ("MACs") more stringently apply the aforementioned rules. For example, many MACs require that claims that change or add a RUG related to the claim must be adjusted within 120 days regardless of whether the MDS was corrected. If the claim is past the 120-day window, the claim is cancelled and must be resubmitted. If the adjustment is for a non-RUG related reason and is outside the one year time frame, MACs will retract the money from the first claim and not provide any Medicare reimbursement for the claim at all. If the claim is less than a year old, the provider must re-bill the corrected claim, which generally results in several weeks between the retraction of the bill, re-billing, and the actual Medicare payment.

Adjustments outside the one year timely billing standards that seek to increase payments to SNFs are not allowed. In some instances, adjustments that decrease SNF payment may be made online but only with the risk the MAC will take back the entire claim without proper reimbursement to the provider or supplier.

All SNFs are required to complete Medicare-required quarterly credit balance reports. Even if there are no credit balances to report, SNFs are required to send a report stating this. Medicare payments are suspended if a MAC does not receive a SNF's quarterly credit balance reports. Quarterly credit balance reports can be used to inform a contractor about an overpayment. However, MACs are quite often slow on recouping the credit balances listed on the reports. In fact, providers routinely have to contact the credit balance departments at the various MACs to determine when the MAC anticipates recouping the funds. In addition, when overpayments are

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[40] Medicare Claims Processing Manual, CMS Pub. 100-04, Chapter 1, § 130.1.
[41] *Id*. at § 130.1.1.
[42] *See* Medicare Claims Processing Manual, CMS Pub. 100-04, Chapter 6, § 30.5.1.

reported on the quarterly credit balance report provided to MACs by SNFs, the money is repaid to Medicare but the original claim never gets corrected—leaving the incorrect claim to be referenced by MACs and auditors, among others, in the future.

3. Reporting and Repayment Obligations Should Only Be Imposed Where "Overpayment" Cannot Be Addressed in the Normal Course of Business

AHCA recommends that CMS impose the overpayment reporting and repayment obligations only in situations where a technical overpayment cannot be addressed and resolved in the normal course of business, by using the claims correction and quarterly credit balance report, for example. Allowing applicable post-payment adjustments to run their course before an overpayment exists would be consistent with CMS comments in previous proposed—but never finalized—rulemakings on reporting and returning overpayments. Specifically, in a 1998 proposed rule related to overpayments, the Health Care Financing Administration ("HCFA") stated "[o]nce a determination and **any necessary adjustments in the amount of the overpayment** have been made, the remaining amount is a debt owed to the United States Government."[43] In another proposed rulemaking regarding the reporting and repayment of overpayments, CMS stated "[s]ubmission of corrected bills in conformance with our policy, within 60 days, fulfills [the reporting and repayment requirements] for providers, suppliers, and individuals."[44] Further, AHCA suggests that CMS suspend the overpayment reporting and repayment requirements in other situations, including other adjustment requests and applicable contractor processes.

AHCA also requests guidance on what a provider or supplier should do if an overpayment has been reported on a credit balance report but a credit balance remains on the providers' or suppliers' books. This scenario could potentially create a duplicate repayment situation and emphasizes the overlapping nature of the credit balance reporting system and the overpayment reporting and repayment.

In addition, AHCA requests that CMS consider extending the timeframes for online claim corrections to allow claims to be truly adjusted rather than merely recouped and resubmitted. This would limit the number of overpayments that would be reported on a special form or quarterly credit balance report and allow for the federal claims database to have correct information related to claims.

E. Proposed Rule's View of "Applicable Reconciliation" is Too Narrow

The Proposed Rule's understanding of "applicable reconciliation" is too limited, and the two exceptions indicated in the Proposed Rule's text, the first related to Supplemental Security Income ("SSI") ratios used in the calculation of disproportionate share hospital ("DSH") payment adjustment and the second related to outlier reconciliation, are far too narrow. AHCA recommends that CMS add exceptions for the reconciliation process to reflect: (1) the results of Recovery Audit Contractors ("RAC") and Zone Program Integrity Contractor ("ZPIC") audits; and (2) participation in voluntary pre-enforcement processes such as SRDP and OIG SDP, as applicable.

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[43] 63 Fed. Reg. 14506, 14507 (Mar. 25, 1998).
[44] 67 Fed. Reg. 3662, 3663 (Jan. 25, 2002).

F. Operational Concerns

1. Continued Use of The Self-Reported Overpayment Refund Forms Is Problematic

AHCA has concerns related to CMS' proposal that providers and suppliers follow the self-reported overpayment refund process set forth by Medicare contractors and utilize the self-reported overpayment refund forms available from the applicable Medicare contractor's web site.

First and foremost, the forms provided by each Medicare contractor are cumbersome and burdensome. Second, the voluntary refund process forms do not easily allow for the reporting of numerous claims at once, and certain Medicare contractors have refused to accept claims that attach an Excel spreadsheet as an addendum to provide information related to multiple, related claims. Third, the Proposed Rule requires that the provider provide extensive information, including the amount of the overpayment. Finally, not all existing self-reported overpayment refund forms contain all of the information required by CMS in the Proposed Rule, and therefore, CMS' guidance requiring providers and suppliers to use these forms seems inconsistent with what it requires providers and suppliers to report under the Proposed Rule.

As noted above, in certain situations, providers may not be able to quickly and easily quantify an overpayment or provide other information required by the voluntary refund process forms and/or CMS in the Proposed Rule. Thus, we reiterate our request that CMS confirm that a provider or supplier does not "identify" an overpayment until it has confirmed all of the information required by CMS, including the amount of the overpayment.

In addition, because of the inconsistencies in various Medicare contractor's self-reported overpayment refund forms, CMS should develop the uniform reporting form prior to finalizing these regulations, and it should address some of the concerns cited, such as the current inability for a reporting provider or supplier to submit multiple, related overpayments at once.

2. CMS Should Adopt a De Minimis Standard or Materiality Threshold in Final Overpayment Rule

When finalizing the reporting and repayment of overpayments rule, AHCA encourages CMS to adopt a de minimis standard or materiality threshold. Specifically, AHCA suggests that if a provider's or supplier's potential overpayment liability is below a certain dollar amount a provider or supplier is not required to report and repay any "overpayment" and will not face any potential liability for not reporting and repaying such an overpayment. It is our understanding that MACs currently settle certain cost reports that include either an overpayment or an underpayment—without an adjustment—because the overpayment or underpayment is below the MAC's materiality threshold. CMS should follow this practice and develop and implement a materiality threshold or de minimis standard in the final Overpayment Rule.

3. Proposed Rule's Collection of Information Requirements Section Dramatically Underestimates Cost of Proposed Rule

The Proposed Rule's Collection of Information Requirements section states:

> For purposes of this section only, we estimate that approximately 125,000 providers and suppliers (or roughly 8.5 percent of the total number of Medicare providers and suppliers) would report and return overpayments in a typical year under our proposed provisions. In addition, we project that each of these providers and suppliers would, on average, separately report and return approximately 3 to 5 overpayments. We also estimate that it would take a provider or supplier approximately 2.5 hours to complete the applicable reporting form and return an overpayment. . . . This, in turn, leads to an aggregate annual

> ICR burden cost, attributable to the impacted 125,000 providers and suppliers for the range of 3 to 5 overpayments, of $34.78 million and $57.97 million, respectively.[45]

Using CMS' estimate for the average hourly rate of staff that CMS believes would be responsible for reporting and returning overpayments, $37.10, which includes fringe benefits and overhead, the reporting and returning of an overpayment would cost approximately $92.75.

In its estimate for the cost of reporting and repaying overpayments, CMS neglects to include a number of costs providers and suppliers would face as they attempt to comply with the Proposed Rule, including: increased compliance costs created by added investigations, audits, and research and improved internal controls; the costs of retaining records for an expansive period of time; the costs associated with investigating whether or not something is an overpayment; and the likelihood that providers and suppliers will involve billing consultants and legal counsel when reporting and repaying overpayments.

In addition, Medicare data seems to suggest that the number of overpayments reported per provider would be significantly higher than the Proposed Rule's estimates. For example, in Fiscal Year 2011, the Medicare fee-for-service error rate was 8.6 percent and Medicare processed 1.2 billion claims.[46] These two numbers indicate that there were an estimated 103 million erroneous claims last year. If there are approximately 1.5 million Medicare providers and suppliers, as the Proposed Rule indicates,[47] there would be approximately 69 erroneous claims per Medicare provider or supplier. However, in its Collection of Information Requirements, the Proposed Rule only accounts for three to five overpayments for 125,000 providers.[48] As a consequence, it seems likely the Proposed Rule dramatically underestimated the number of overpayments providers and suppliers will be reporting and repaying, and therefore likely underestimated the cost to providers and suppliers.

As noted above, we believe that the Proposed Rule's Collection of Information Requirements dramatically underestimates the cost of the Proposed Rule to providers and suppliers because it: (1) neglects to account for various costs that would be incurred due to the Proposed Rule's requirements, such as record retentions costs; (2) potentially underestimates the number of overpayments providers and suppliers would be reporting and repaying; and (3) disregards the likely use of legal counsel and billing consultants in the overpayment reporting and repayment process. AHCA advises that CMS reconsider the Proposed Rule's estimated costs associated with the reporting and returning of overpayments in light of the aforementioned concerns.

IV. CONCLUSION

In conclusion, we again express our appreciation to CMS for working with stakeholders to effectively implement various ACA provisions. We stand ready to assist you in developing

[45] 77 Fed. Reg. 9179, 9184-85 (Feb. 16, 2012).
[46] Department of Health and Human Services, FY 2011 Agency Financial Report, available at http://www.hhs.gov/afr/2011afr.pdf; *see* http://www.hhs.gov/asl/testify/2010/07/t20100715a.html.
[47] The Proposed Rule states that 125,000 providers and suppliers constitute roughly 8.5 percent of the total number of Medicare providers and suppliers. Using this information, there are approximately 1.5 million Medicare providers and suppliers. 77 Fed. Reg. 9179, 9184 (Feb. 16, 2012).
[48] 77 Fed. Reg. 9179, 9184 (Feb. 16, 2012).

appropriate policies impacting the long-term care industry.

We thank you for consideration of our recommendations, and we would be pleased to answer any questions you may have.

Sincerely,

Elise Smith
Senior Vice President for Finance Policy and Legal Affairs

cc: Mark Parkinson
Peter Budetti
Jonathan Blum
Laurence Wilson
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