"Hope Springs Eternal"
Will CMS Do A Reality Check Before Finalizing Its New Proposed Rule On Reporting and Returning Overpayments?

James A. Robertson

Cecylia K. Hahn

John W. Kaveney

by James A. Robertson, Cecylia K. Hahn and John W. Kaveney

Since the adoption of the Patient Protection and Affordable Care Act (the "ACA"),[1] the Federal Government has flooded the public with a seemingly endless flow of proposed regulations intended to implement the ACA. A recent set of regulations which is causing quite a stir was published by the Centers for Medicare & Medicaid Services ("CMS") on February 16, 2012. The proposal seeks to implement section 6402(a) of the ACA by adding a new Subpart D to Part 401 of its regulations, entitled "Reporting and Returning of Overpayments."[2]

Section 6402(a) of the ACA requires that an overpayment be reported and returned by the later of (1) the date which is 60 days after the date on which the overpayment was identified; or (2) the date any corresponding cost report is due, if applicable. Notably, the proposed regulations are significantly more expansive than the language of the statute. Hoping for the best but preparing for the worst, the provider community, including acute care hospitals, inpatient rehabilitation facilities, home health and hospice agencies, and physicians, has faithfully submitted comments and now awaits adoption of the final rule. However, no one knows whether the government will adequately address what has been identified as some of the major problems in the proposed regulations.

Will the Final Rule Properly Define What Is Meant By "Identified?"

Perhaps the most critical issue that needs to be addressed is what Congress means by the word "identified" when providers are directed to return overpayments to CMS within 60 days after an overpayment is "identified." In fact, the ACA does not define this term. Clarification is necessary for proper compliance with the requirements for reporting and returning overpayments and lack of clarity could have serious repercussions.

Central to the providers' concerns is that proposed §401.305(a)(2) adds an unintended dimension to the term "identified" by incorporating into §401.305(a)(2) the False Claims Act definition of "knowledge."[3] As it stands, the proposed language 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 the overpayment.***" By liberalizing the scope of knowledge that is required, the proposed rule significantly lowers the threshold for potential liability. "Actual knowledge," a more certain standard which many believe is what Congress intended, is replaced with the more amorphous standards of "reckless disregard" and "deliberate ignorance" whose ambiguous nature fails to adequately inform health care organizations of the circumstances that would give rise to this new and more burdensome duty to investigate.

To lessen the anxiety over its approach with regard to the concept of "identifying" an overpayment, CMS has made a passing reference to a temporal dimension. The preamble to the proposed rule requires that a reasonable inquiry be conducted to determine whether an overpayment exists and, if after a reasonable inquiry, an overpayment is identified, then the 60-day clock begins to run. While the idea of reasonable inquiry may make sense, there is again, too much uncertainty for the provider community to have any faith in its even-handed application. In the real world, the issues involved in a potential overpayment inquiry are not simple, but rather, require an in-depth

financial, reimbursement, and legal analysis which takes time, effort, and human and financial resources. So, for example, if after a reasonable inquiry an overpayment is revealed, it is completely unclear how much time a provider would have to ***quantify*** the overpayment. Moreover, the provider community has not been informed what would happen if a reasonable inquiry did not reveal an overpayment, but an overpayment was later discovered by CMS. As a result, completely lacking from the regulatory discourse is the familiar concept of conducting a reasonable inquiry in good faith. While a balance must be struck with the Government's need to recoup legitimate overpayments, the practical realities providers face to accurately identify and quantify overpayments, especially given limited resources, must also be adequately recognized.

It has been suggested by some experts that CMS has watered down the threshold for a provider to have "identified" an overpayment because CMS distrusts that providers will otherwise perform audits, compliance checks, and additional research to determine whether an overpayment was made. However, if this suggestion is accurate, it is offensive, given the provider community's voluntary efforts and commitment to compliance since the late 1990s.

Hope springs eternal and CMS may capitulate and incorporate many providers' suggestions that the final rule set forth in its text a clear and focused definition of "identified" – one that coincides with Congress' intent: actual knowledge. The provider community is also entitled to the time that is often needed to quantify the amount of an overpayment and, so long as the provider engages in a good faith effort to quantify the overpayment, if any exists, the 60-day clock should not begin to run on the provider's obligation to make the repayment.

Will the Final Rule Exclude Costly and Unnecessary Reporting Requirements?

Proposed § 401.305 requires a provider who has received an overpayment not only to return the overpayment to the Federal Government using the existing voluntary refund process, but also to report the following information to CMS:

- How the error was discovered.
- A description of the corrective action plan implemented to ensure the error does not occur again.
- The reason for the refund.
- Whether the provider or supplier has a corporate integrity agreement ("CIA") with the OIG or is under the OIG Self-Disclosure Protocol.
- The time frame and the total amount of the refund for the period during which the problem existed that caused the refund.
- If a statistical sample was used to determine the overpayment amount, a description of the statistically valid methodology used to determine the overpayment.[4]

The question that arises is whether these additional reporting requirements are truly necessary or whether they are too burdensome and inconsistent with the policy of encouraging expeditious return of overpayments. Many providers have pointed out to CMS that the purpose of the voluntary refund process is to allow CMS to appropriately match claims information with the information that is reported by the provider and to understand the nature of the overpayment. Submission of the required form provided by the Medicare contractor adequately satisfies these objectives.

In addition, these new reporting requirements fail to take into account that existing compliance programs and activities are built on the current rule and processes for billing and payment. These existing policies, which are technically not changed by the new ACA provision, should be permitted to remain in place and not be changed by CMS through its new rule. An example is helpful. The new requirement to describe the corrective action plan implemented to ensure an error does not occur again is unduly burdensome as it neither identifies the claim nor explains the overpayment. Further, if implemented as written, the proposal would require a corrective action plan for an error that may have occurred *many years* in the past and which will not occur again based on current practice management systems and/or enhanced electronic medical records technology. To require the provider to explain and implement a corrective action plan would serve no meaningful purpose. But would a provider take the chance and say no corrective action plan is necessary? It could, but would run the risk that CMS will disagree; and then what might happen?

CMS has lost sight of the fact that the reporting requirements should be conservative and cause as little economic impact on providers as possible. Requiring providers to gather more information than is necessary and expend resources to change completely adequate policies or processes, or conclude that no corrective action is necessary and run the risk that CMS is dissatisfied with what may be, in reality, a completely reasonable approach to the issue would be inappropriate, uneconomical and heavy-handed.

Will the Final Rule Contain a Realistic Lookback Period Which is Shorter than 10 Years?

Proposed § 401.305(g) creates a 10-year lookback period for reporting and returning overpayments. In the preamble to the proposed rule, CMS states that it selected a 10-year lookback period because this timeframe is the maximum lookback period under the False Claims Act. However, if CMS were being intellectually honest, it would recognize that there is no statutory authority to apply what would in effect be an extended 10-year statute of limitations period for repayment of overpayments.

continued on page 18

continued from page 17

There is no question that the lookback period in proposed § 401.305(g) creates a direct 10-year link to the False Claims Act – a link that does not currently exist for overpayments, and a link that should not exist. While § 1128J(d) of the SSA provides that any overpayment retained by a person after the deadline for reporting and returning the overpayment is an obligation for the purpose of 31 *U.S.C.* § 3729 of the federal False Claims Act, even the False Claims Act recognizes that the primary statute of limitations for a violation of section 3729 is only 6 years. This 6-year statute of limitations can be extended to no more than a ten-year period, but only in certain limited cases "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."[5] The effect of CMS' administrative creativity is that a provider can now be charged with having "identified" an overpayment, ***which existed 10 years ago,*** even if no individual was aware of or recognized that the provider had received an overpayment, ***and face False Claims Act liability!*** And, to add insult to injury, CMS has failed to identify ***who*** in the organization is required to be aware of the overpayment.

It is clear that the ACA says nothing about a statute of limitations period. Indeed, the only reason we are having this debate is because CMS, through its administrative power to propose and adopt regulations, has replaced the "actual knowledge" standard for repayment of overpayments by incorporating the more liberal standards of "reckless disregard" and "deliberate ignorance," neither of which exists in the ACA. Indeed, these new, vague, and quite frankly, potentially deceptive standards create the bridge the federal government needs to transform the 10-year "lookback" period for overpayments into a 10-year "statute of limitations" for a false claim. By linking these new standards in proposed § 401.305(g) to the 10-year lookback period and § 1128J(d) of the SSA, CMS has cleverly created, without Congressional authorization, an expansive obligation for providers that does not exist anywhere else in current law.

Legal mumbo jumbo aside, there are many reasons why it is improper to equate overpayments to false claims. In its April 16, 2012 comment letter to the proposed regulations, the Health Law Section of the American Bar Association[6] pointed out obvious differences between the False Claims Act, which deals with false or fraudulent claims, and a law dealing with overpayments, which are more benignly defined as "any funds that a person receives or retains under [Medicare or Medicaid] to which the person, after applicable reconciliation, is not entitled," with no necessary imputation of fraud, falsehood or other culpable behavior. Examples of overpayments which were noted by CMS include, but are not limited to: (i) Medicare payments for noncovered services; (ii) Medicare payments in excess of the allowable amount for an identified covered service; (iii) errors and nonreimbursable expenses in cost reports; (iv) duplicate payments; and (v) receipt of Medicare payment when Medicare was the secondary payor and not the primary payor.[7] All of these examples have one thing in common – they are improper payments that can arise without any evidence of fraud. Thus, while the 10-year outer limit of the False Claims Act's statute of limitations may be appropriate for fraudulent claims, in certain limited circumstances, there is no question that it is excessively punitive where an innocent billing error is made by the provider (or even a payment error by the Medicare or Medicaid Programs themselves, such as a duplicate payment), which results in an overpayment that has been retained by mistake.

CMS has glibly stated that, as a practical matter, the 10-year lookback period is appropriate because it allows providers to have certainty after a "reasonable period" and close their accounting books. To the contrary, the extraordinary lookback period creates prolonged uncertainty and fails to reflect any reasonable balance of interests, instead placing an extended burden squarely on the shoulders of the provider community.

There is no secret that providers, especially hospitals, face numerous practical obstacles in their efforts to adequately identify overpayments. For example, patient cooperation is a complete wildcard. Between the time of service and identification of an overpayment, a patient may move, die, obtain new coverage and dispose of or misplace prior records, and/or suffer deterioration in mental capacity. More often than not, patients refuse to cooperate with providers regarding claims of long ago. Even if the patient is located, the much shorter statute of limitations enabling a provider to collect from the patient may have run, precluding the provider from receiving any payment whatsoever.

The existing Medicare reopening rules provide for a three- or four-year lookback period, depending on the circumstances and the payment system under which the claim was paid. There is no suggestion that this current lookback period or the existing claim reconciliation and correction processes including, for example, claim corrections procedures, are in anyway inadequate. In fact, the current lookback period and claims processes take into account the practical realities providers face when dealing with extraordinarily complex issues that arise in obtaining reimbursement for medically necessary services that are rendered appropriately.

CMS must not lose sight of the fact that while it is squeezing providers on the back end of the reimbursement process, providers are also being squeezed on the front end. At the same time that CMS is expanding the time period for reporting and returning overpayments, under the ACA, § 6404, the period of time for submission of Medicare claims has been reduced to only 12 months. As we are seeing, Medicare contractors routinely reject claims and appeals by providers

for services older than one year. This means that if a claim is submitted 12 months and one day after the deadline, that provider will not receive payment for these otherwise covered services. The limitations placed on providers by the ACA, as further expanded by CMS make for a dismal, discouraging and uncertain financial environment for providers.

Finally, if the final rule contains a lookback period that has some semblance of the expanded 10-year lookback period, providers are hoping that the new period, whatever the length, will apply ***prospectively only,*** i.e., begin to run on claims for services rendered as of the adoption date of the Final Rule. The concern is that if CMS decides to apply the Final Rule retrospectively, the effect would be to unnecessarily force providers to open books they have had closed for years. Prospective application would, at the very least, allow the necessary time to develop information systems and technology to provide ready access to claims reflecting potential overpayments. As currently drafted, the proposed rule would divert providers' financial and human resources away from their traditional mission of providing care to endlessly searching for the proverbial overpayment "needle" in a Medicare claims "haystack."

Conclusion

Implementation and compliance with the ACA is going to be expensive. The Federal Government will be responsible for many of these expenses, including for example, funding or partially funding local health care exchanges and paying for expanded Medicaid benefits in states that choose to participate in the Medicaid expansion program. Congress and CMS have been and will continue to be creative in finding new revenues to pay for the additional financial commitments under the ACA. One creative maneuver is CMS' current attempt, through the proposed rule, to significantly expand the potential liability, obligations, and lookback period for reporting and returning overpayments. The proposed rule does not bode well for the provider community, and the hope is that CMS will listen to the provider community's comments and incorporate a more balanced approach when promulgating the Final Rule.

About the Authors

James A. Robertson is a Partner and head of the health care practice at McElroy, Deutsch, Mulvaney & Carpenter LLP, with ten offices in New Jersey, New York, Connecticut, Massachusetts, Pennsylvania, Delaware, and Colorado. Jim can be reached at: jrobertson@mdmc-law.com.

Cecylia K. Hahn and John W. Kaveney are associates in the health care practice at McElroy, Deutsch, Mulvaney & Carpenter LLP.

Footnotes

[1]The ACA was adopted on March 23, 2010 and upheld, in significant part, by the Supreme Court of the United States on June 28, 2012. 124 Stat. 119-1025; *National Federation of Independent Business et al. v Sebelius,* 567 U.S. _____ (2012). As President Obama was re-elected on November 6, 2012, the chances that the ACA will be repealed are now slim to none. Obamacare (a nickname for the ACA that the President has embraced) is here for the long haul.

[2]77 *Fed. Reg.* 9179.

[3]31 *U.S.C.* § 3729(b).

[4]These additional requirements are found in proposed § 401.305(d)(3), (4), and (9) through (12).

[5]31 U.S.C. § 3731.

[6]April 16, 2012 Letter from David H. Johnson, Chair, ABA Health Law Section, to CMS Administrator Marilyn Tavenner.

[7]Id. at pp. 12-13, *citing,* 77 *Fed. Reg.* at 9181.

Meet A New Member!

Michael A. Mellace	
Who is your employer, and what is your position?	Crozer-Keystone Health Systems, Senior Grant Accountant.
What was your first job as a teen?	Paperboy. I don't think they exist anymore. Now it's adults delivering the paper at 5am so you can have it with your morning coffee. What a shame.
What do you like best about your work responsibilities?	Although my job title is Senior Grant Accountant, I am more of a Grants Manager, as our system does not have one. I love the impact I have had on increasing our cash flow and changing the people's understanding that grants don't have to lose money.
A job I would enjoy doing without pay is...	Foundation Director. You can find plenty of money out there for worthy causes, but you must first change the old school mentality of how to fundraise.
My favorite place is...	Disney World.
I will not eat...	I have never met a food I didn't like.
If I'm not at work, you will find me...	With my two beautiful children.