Proskauer

CMS's Proposed Rule on Medicare Overpayments

February 28, 2012

On February 14, 2012, the Centers for Medicare and Medicaid Services (CMS) proposed a rule implementing Section 6402(a) of the 2010 Affordable Care Act (ACA)[1], which requires health care providers and suppliers to report and return Medicare and Medicaid overpayments no later than 60 days after the overpayment was identified or the date any corresponding cost report is due. At least since the adoption of the ACA, the failure to report and repay an overpayment creates an "obligation" potentially leading to a false claim, bringing to the fore the question of how providers can address overpayments they discover. The proposed rule[2] does not change these statutory reporting requirements. Instead, the proposed rule provides guidance and procedures for reporting and returning overpayments to Medicare for providers and suppliers under Parts A and B. The announcement of the proposed rule on the same day that Department of Justice (DOJ) Attorney General Eric Holder and Department of Health & Human Services (HHS) Secretary Kathleen Sebelius released the 2011 Annual Report on the Health Care Fraud and Abuse Control (HCFAC) program illustrates the increased coordination among CMS, HHS, DOJ, OIG and the states to prevent fraudulent payments, and to obtain repayments where possible.[3]

The Proposed Rule

Below are the key points from the proposed rule that may significantly impact health care providers and suppliers:

- **Overpayment** means any funds that a person has received or retained under title XVIII of the Act to which the person, after applicable reconciliation, is not entitled under such title. *See* § 401.303. For example:
  - Payments for noncovered services
  - Payments in excess of the allowable amount
  - Errors and nonreimbursable expenditures in cost reports
  - Duplicate payments

    - Receipt of payment when another payor had the primary responsibility for payment

- The proposed rule provides that “an overpayment must be reported and returned by the later of – (i) the date which is 60 days after the date on which overpayment was identified; or (ii) the date any corresponding cost report is due, if applicable.” However, availability of the cost report deadline extension is limited to situations in which reconciliation of the cost report will determine whether there is an overpayment – for example, for graduate medical education payments. Thus, in most cases, the 60-day rule will apply. 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 overpayment.
    - CMS believes that this definition incentivizes providers and suppliers to exercise reasonable diligence to determine whether an overpayment exists.

- The proposed rule renames the existing voluntary refund process to be called “self-reported overpayment refund process.” This refund process eliminates any possibility of making a “stealth” repayment. If providers and suppliers identify an overpayment they must submit a report that summarizes:
    - 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 there is a corporate integrity agreement (CIA) or OIG Self-Disclosure Protocol in effect
    - Time frame and amount of refund
    - Whether a statistical sample was used to determine the overpayment.

- CMS will work on a uniform form to be used by all contractors for this purpose.
- The proposed rule recognizes that there will be **overlap and multiple reporting obligations** by providers and suppliers to different government agencies. For example, while filings under the OIG Self-Disclosure Protocol and the Medicare Self-Referral Disclosure Protocol both suspend the running of the 60-day deadline, the proposed regulations as drafted do not relieve providers who have made a disclosure to CMS of potential Stark law violations of the responsibility to make a report to the contractor. CMS is seeking comments on alternative approaches that would allow providers and suppliers to avoid making multiple reports of identified overpayments.

- The proposed rule seeks to amend the definition of "**hardship**" to address the potential financial limitations associated with the ability of the provider or supplier to repay the overpayment. Under the existing Extended Repayment Schedule (ERS), if a provider or supplier needs additional time to repay, they must submit significant documents to prove financial hardship. It is unclear based on the revised definition how the proposed rule will make it easier for the provider or supplier to claim hardship.
- Significantly, the proposed rule imposes a **ten-year look-back** period for identifying overpayments. The preamble to the proposed rule indicates that this is the outer limit of the statute of limitations under the FCA.[4] The proposed rule could open providers and suppliers to FCA liability, Civil Monetary Penalties and even exclusion from Federal health care programs for overpayments that happened almost ten years ago. In theory, however, the self-reporting obligation could have been timeless (i.e., at least back to the beginning of Medicare), so the proposed regulations at least provide a date of repose.

CMS encourages providers and suppliers to submit comments to the proposed rule by April 16, 2011. Click here to see the proposed rule that was published in the February 16, 2012 *Federal Register.*

If you have any questions about CMS's proposed rule on reporting and returning Medicare overpayment or on any potential FCA liability, please contact Richard J. Zall, Edward S. Kornreich, Elizabeth M. Mills, Ryan P. Blaney, or a member of Proskauer's Health Care Team.

[1] The "Affordable Care Act" means the Patient Protection and Affordable Care Act ("PPACA") and the Health Care and Education Reconciliation Act of 2010 ("HCERA"). For more information about the Acts, please click here to visit our Health Care Reform Task Force Web site.

[2] *See* the March 25, 1998 (63 FR 14506) and January 25, 2002 (67 FR 3662) proposed rules.

[3] According to the annual report, DOJ and HHS recovered $4.1 billion in fraudulent health care payments in 2011. DOJ and HHS expect to add new Medicare Fraud Strike Force teams in 2012 and to implement additional advanced fraud detection technology to more effectively identify fraudulent claims. Click here to see the full 2011 Annual Report.

[4] Civil penalties for violations of the FCA include tremble damages and statutory penalties up to $11,000 for each false claim. *See* 31 U.S.C. § 3729.

Related Professionals

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