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CMS Publishes Proposed Rule on Return of Medicare and Medicaid Overpayments

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Health care providers and suppliers concerned about how the **Centers for Medicare & Medicaid Services (CMS)** plans to implement the 60-day deadline for returning Medicare and Medicaid overpayments enacted as part of the **Affordable Care Act (ACA)** now have a **proposed rule** that provides some insight.

Section 6402(d) of the ACA created a new **section 1128J** of the **Social Security Act**, and it establishes that the failure to report and return an overpayment within 60 days of identifying its existence can give rise to liability under the False Claims Act (FCA). The proposed rule applies only to overpayments identified by Medicare Part A and B providers and suppliers, but CMS made clear that Medicare Advantage Organizations, Medicaid Managed Care Organizations, and Prescription Drug Plans under Medicare Part D still have an obligation under various statutes to report and return overpayments.

Overpayment Identification

Since the enactment of section 1128J, providers and suppliers have wondered when the 60-day clock begins to tick. CMS attempted to address this issue but left many questions unanswered. According to the proposed rule, an overpayment is "identified" if the provider or supplier has actual knowledge of the existence of the overpayment or acts in reckless disregard or deliberate ignorance of the overpayment. CMS believes that this standard, which is consistent with the False Claims Act, will motivate providers and suppliers to exercise reasonable diligence to determine whether an overpayment exists.

CMS acknowledged that providers and suppliers may need time to conduct a "reasonable inquiry" after receiving information regarding a potential overpayment (e.g., a compliance hotline report) to confirm that an overpayment was in fact received. In such cases, reporting and return of the overpayment must occur within 60 days of completing the inquiry. To illustrate application of the requirement, CMS provided a number of examples but offered very little concrete guidance on how it will determine whether an inquiry is "reasonable." It did note, however, that failure to act "with all deliberate speed" could result in the provider or supplier knowingly retaining an overpayment.

Section 1128J allows providers who submit cost reports to report certain types of overpayments when the cost report is due rather than within 60 days of identification, but CMS made clear that such providers cannot delay the return of claims-based overpayments. For example, a provider may report an overpayment of graduate medical education funds at the cost report deadline, but overpayments resulting from inaccurate coding of claims must be returned within 60 days of identification.

Process for Reporting and Return of Overpayments

Providers and suppliers would report overpayments to the appropriate Medicare contractors using the existing voluntary refund process in Chapter 4 of the **Medicare Financial Management Manual**, which will be renamed the "self-reported overpayment refund process." Because the self-disclosure mechanisms employed by CMS and the **Office of Inspector General** (OIG) may create duplicate reporting obligations, CMS proposed that providers and suppliers who report overpayments through the OIG **Self-Disclosure Protocol** should not also report and return overpayments through the self-reported overpayment refund process. But providers and suppliers who report overpayments through CMS's **Self-Referral Disclosure Protocol** still must go through the self-reported overpayment refund process because the 60-day requirement would only be suspended with regard to the Stark self-referral statute-related component of the overpayment. CMS is seeking comment on alternative approaches that would eliminate the need for multiple reports of identified overpayments.

The Lookback Period

For now, CMS has determined that all providers should report overpayments that may have occurred within a ten-year lookback period, which is consistent with the ten-year statute of limitations under the False Claims Act. CMS believes that this requirement will offer providers and suppliers certainty and

that it will sufficiently further its interest in the timely return of overpayments. CMS therefore proposed an amendment to the reopening rules to allow for this change. At present, the reopening rules state that the Medicare contractors can reopen claims within one year for any reason, within four years for "good cause," and any time if evidence of "fraud or similar fault" exists. Absent any evidence of wrongdoing, providers and suppliers who identify overpayments typically repay claims received within the last four years. If the reopening rules are amended to require repayment of claims over a ten-year period, providers and suppliers will be required to repay at least ten years' worth of claims in all cases.

Areas for Comment and Comment Period

CMS is specifically seeking comment on anticipated burdens and costs associated with the proposed rule's reporting and repayment requirements, the appropriateness of the ten-year lookback period, and other ways to alleviate provider and supplier burdens that may arise from complying with the increased overpayment reporting and repayment obligations under the ACA. These comments are due by **April 16, 2012.** In the meantime, providers and suppliers should act quickly when investigating potential overpayments and document all steps in the investigation to ensure the ability to document that the inquiry was "reasonable" and conducted with "all deliberate speed."

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