



**American Hospital
Association**

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Submitted electronically

April 16, 2012

Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Room 445-G
Washington, DC 20201

Re: Medicare Program; Reporting and Returning Overpayments (CMS-60037-P)

Dear Ms. Tavenner:

On behalf of our more than 5,000 member hospitals, health systems and other health care organizations and our 42,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule to implement Section 6402(a) of the *Patient Protection and Accountable Care Act* (ACA), which creates a reporting and repayment obligation for providers and suppliers who receive an overpayment. We have significant concerns about the proposed rule and the negative effect it will have on hospitals.

America's hospitals have a longstanding commitment to compliance. Across the field, organizations have made investments in compliance programs and resources to support them in doing their best to assure that each hospital receives the payment to which it is entitled. On an annual basis, Medicare processes more than 150 million claims for hospital services. Predictably, mistakes are made by hospital staff, CMS staff and Medicare contractor staff alike.

The AHA has advocated for a clear and efficient process for the return of overpayments that result from mistakes. We viewed this provision in the ACA, and Congress intended it, as a means to correct mistakes. Instead, the law is being contorted by this proposed rule to create another confusing, onerous, and legally risky set of expectations for hospitals: confusing because there is no acknowledgment or consideration of the overlap, inconsistency and contradictions with the already existing world of Medicare billing



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processes and the program's many and varied post-payment audits and reviews; onerous because the proposal would require the diversion of resources - staff time, dollars and information technology (IT) systems - to make needed changes to *try* and meet the unreasonable and often impossible timeframes and to conduct the sweeping and unfounded reviews of current, past and long-past records and submissions; and legally risky because the proposed rule is attempting (without legal authority) to wrap all of these unreasonable and impractical expectations in the cloak of *False Claims Act* liability. We discuss each of these concerns in the attached detailed comments.

We urge that you revisit the proposed rule's framework for implementation of the law in its entirety. The emphasis should be on minimizing unnecessary burden and assuring coordination with the many existing and varied reviews, reviewers and processes already imposed on hospitals. And, the agency should do so in accord with the clear intent of the law to provide a safe and reliable way in which hospitals can return payments mistakenly received from the government. Our detailed comments are attached.

We stand ready to work with you to improve the final rule to achieve the law's intended outcome. If you have any questions, please contact me or Maureen Mudron, AHA deputy general counsel, at mmudron@aha.org or (202) 626-2301.

Sincerely,

/s/

Rick Pollack
Executive Vice President

AMERICAN HOSPITAL ASSOCIATION DETAILED COMMENTS REPORTING AND RETURNING OVERPAYMENTS

Congress enacted the overpayment provision in the *Patient Protection and Affordable Care Act (ACA)* as a result of expansions to the *False Claims Act (FCA)* in the *Fraud Enforcement and Recovery Act of 2009 (FERA)*. In FERA, Congress made “retention of an overpayment” a basis for FCA liability. It was added in response to concerns that a contractor or other recipient of federal funds would recognize an overpayment had occurred and either not return the funds or significantly delay a return to reap further unearned financial benefit. Prior to enacting the overpayment provision in the ACA, there was no explicit statutory obligation in the *Social Security Act* to return overpayments from the Medicare and Medicaid programs. The purpose of this provision was to fill that gap by making clear a duty to repay arose when a provider “identified” an overpayment.

The ACA overpayment provision was intended to fill a perceived gap in law and should be implemented to achieve only that purpose. The Centers for Medicare & Medicaid Services’ (CMS) proposed rule attempts to do something Congress did not intend. Indeed, by taking such an expansive view, the proposed rule is contorting the intent of Congress and the consequences are confusion and unnecessary burden and exposure of hospitals to unauthorized FCA liability.

OVERPAYMENT PROCESSES ALREADY IN PLACE

The final rule should not apply when existing processes already address overpayments. The limited purpose of the overpayment provision becomes even clearer after a review of existing administrative processes to allow hospitals and other providers to reconcile and return overpayments. None of these processes are changed by the overpayment provision. In fact, the provision explicitly defers to the process of reconciliation in deciding when the 60-day clock for repayment begins. Congress made clear that the other provisions were not affected by leaving them undisturbed.

Whether the proposed rule was written in a vacuum or was intended to interrupt existing processes, the final rule should be clear that it does not apply to existing processes that can address overpayments. The language of the proposed rule is sweeping in its application. The fact that the proposed rule both acknowledged and created carve-outs for CMS’s Self-Referral Disclosure Protocol and the Office of Inspector General’s (OIG) Self-disclosure Protocol reinforces our concern about the failure to confirm it does not apply to other administrative processes.

The Medicare billing and payment processes can be grouped into three categories: billing, claims reconciliation and post-payment reviews and audits. A hospital submits claims on an ongoing basis and a “cost report” at the end of the year. During the course of the year, hospitals correct claims with self-identified problems and additional adjustments can be made through the post-payment reviews by external entities. For the cost report, current audit processes are in place and, for those providers paid under Periodic Interim Payment, the hospital and government reconcile the ultimate amount due the hospital for services provided to beneficiaries during the year (which may result in hospital challenges through the appeals process).

All processes are handled by contractors on behalf of the government (e.g., Medicare Administrative Contractors (MACs) and Recovery Audit Contractors (RACs)). All processes are administered through excruciatingly detailed regulations and manuals around which hospitals have built information systems and programs, operations manuals and compliance initiatives. None of these processes should have to be changed because of the proposed rule; these include:

“Timely Filing.” Currently, hospitals may submit claims to Medicare for up to 12 months after the date of service. If, in that same 12-month period, a hospital discovers an error, it may correct the initial claim by submitting an adjustment claim. The adjustment claim is processed by the contractor through recoupment of the original amount paid and issuing a new payment for the correct amount. The proposed rule offered no justification for changing this process and the related operational changes a hospital would have to make.

Ongoing Submissions. Medicare requires providers to submit quarterly credit balance reports related to claims, identifying any credit balance due on Medicare account and submitting payment to the MAC. This process also is not recognized by the proposed rule.

Reconciliation Process. Certain hospitals, particularly critical access hospitals (CAHs) and some teaching facilities, receive “interim” reimbursement throughout the year for expected amounts calculated by the contractors based on prior reimbursements. At the end of the year, the hospital prepares and submits a “cost report” – data on the Medicare-payable costs that it incurred and the interim payments that it received over the course of the year. The cost report is due approximately five months after the end of the cost-reporting year, during which any overpayments it discovers also could be corrected with no penalty under the current system.

Once in the contractor’s hands, the cost report is reviewed for any errors in billing or payment (overpayments or underpayments). The contractor then issues a Notice of Program Reimbursement, which is the official notification of the

amount a hospital was entitled to for care provided to beneficiaries. If there was an overpayment, that amount must be appealed or returned within 180 days. The proposed rule's blanket application would interfere with this process and result in the premature return of payments to which the government is not ultimately entitled. Congress was aware of this process. The overpayment provision did not change it; consequently, the proposed rule should not interfere with it. It also takes an unreasonably narrow view of the statute's language tolling the 60-day deadline for related cost report filings. The 60-day deadline for repayment should be tolled for claims and other adjustments that currently can be made during the reconciliation process.

Similarly, announcements by CMS that problems with its system have resulted in overpayments should be addressed through the correction process specific to the problem. For example, in March CMS announced that information it supplied that was needed by hospitals to submit cost reports had changed and that cost reports going back to 2006 would have to be revisited (i.e., new Supplemental Security Income ratios were required). CMS advised that any payment implications (under- and overpayment) would be handled by the MAC cost report auditors' processing adjustments to filed cost reports and determining any needed adjustments. The proposed rule appears to call for hospitals to bear the burden of taking the initiative when, in fairness, CMS should, and indeed intended to, handle the corrections.

MAC and RAC Reviews. In addition to the processes for billing and reconciliation, there are post-payment audit and review programs conducted by the MACs and RACs, among others. All are focused on assuring that the government pays and hospitals receive the payment to which they are entitled for providing care to Medicare beneficiaries. Each has appeal processes.

While hospitals continue to be concerned about the processes and results of these reviews and the unnecessary burden caused by their overlap, the proposed rule will only make things worse because it would alter and diminish the existing rights and remedies hospitals have to dispute the findings. CMS is well aware of hospitals' significant concerns about the implementation of these programs and the striking, but not unexpected, rate at which RAC overpayment findings have been reversed by CMS Administrative Law Judges. The RACs' authority to recoup alleged overpayments is suspended while on review and in the event of a final determination that an overpayment occurred, repayment may occur through withholds from future payments.

The same methodology used within the RAC program is in place for post-payment reviews by the MACs. Providers receive notice of an overpayment, have the opportunity to immediately repay and proceed with an appeal, repay and not appeal, OR merely appeal the determination. In the latter case, the potential

overpayment accrues interest that is payable if the provider ultimately loses at the appeals level.

CMS should move promptly to remedy the confusion it has created regarding the intersection of the proposed rule and all of the existing processes. It should confirm that this rule does not apply to individual claims or types of claims that are the subject of any government review. While the preamble makes a passing statement that providers must comply with current procedures when CMS or a contractor issues a demand letter for an overpayment, the proposed rule never hints that its application is constrained by those processes. Nothing in the legislative history of the overpayment provision suggests that Congress intended to override providers' existing rights and avenues for relief under government audits.

Lastly, as noted, the proposed rule created carve-outs for the CMS and OIG self-disclosure protocols. For some unexplained reason, however, the proposed rule requires duplicate reporting under this rule and the CMS self-disclosure protocol. **The final rule should eliminate this duplicate reporting.** If information needs to be shared within CMS, that should be handled as an internal matter and not a burden for hospitals to assume.

ONGOING COMPLIANCE ACTIVITIES

The proposed rule imposes unreasonable and impossible expectations under threat of FCA liability. The two most concerning aspects of the proposed rule are its attempt to create a broad-based and ill-defined duty to investigate any possibility of a potential overpayment under pain of FCA liability, and the ten-fold magnification of the problem by coupling it with a "look back" period of 10 years – an extraordinary expansion from four to 10 years – whenever a hospital recognizes an overpayment.

"Duty to Investigate." As the preamble explains, the statute starts the 60-day clock for repayment running when and if an overpayment is "identified." The statute does not define identified; nor does the proposed rule. **Instead, the proposed rule substitutes the word "knowing" in place of "identified" and creates a cascade of problems.** First and foremost, it ignores what Congress said ("identified"), what Congress did (enact only a duty to repay), and ignores the import of what Congress meant (e.g., recognized, actually known, acknowledged). Worse, by assuming Congress meant something it did not say and inserting the FCA definition of "knowing" into the mix, the proposed rule significantly lowers the threshold from actual knowledge (what Congress intended) to "reckless disregard" and "deliberate ignorance," ambiguous terms that do not adequately inform hospitals of the circumstances that would give rise to this new and burdensome duty to investigate. **The result: A hospital can be charged with having identified an overpayment even if no individual was aware of or recognized that it had received an overpayment and face FCA liability.**

To avoid liability, a hospital would effectively have to guarantee that its bills and reviews were 100 percent accurate 100 percent of the time. This is an impossible standard for hospitals...as well as for CMS and its contractors. The explanation given for this overreach: “Without such a definition [of “identified”] some providers and suppliers might avoid performing activities to determine whether an overpayment exists, such as self-audits, compliance checks and other additional research.” **The AHA strongly disagrees with the shadow the proposed rule casts on hospitals’ commitment to compliance as well as the legal underpinnings for the proposed rule’s framework (discussed in more detail below).**

Hospitals have a longstanding commitment to voluntary compliance activities. Their compliance programs are designed to meet principles for effectiveness outlined in the U.S. Sentencing Guidelines and more specifically in the OIG’s compliance program guidance for hospitals. Hospital staff strives every day to comply in good faith with the complex and continually changing legal and regulatory requirements to receive payment for serving Medicare beneficiaries. Hospitals’ compliance programs extend beyond having processes in place to respond to individual situations brought to their attention to include systems designed to track changes and training and education to stay current with the requirements. Hospitals invest substantial resources to monitor their bills for mistakes and assign responsibility for these proactive efforts to internal auditors and compliance officers.

Hospitals operate under a standard of reasonableness and commit resources to problems that are reasonable under the circumstances. The final rule should recognize and affirm the legitimacy of this approach. Hospitals must plan for and manage inputs from many sources about what may be potential overpayments (e.g., calls on a hotline, questions from staff, internal reviews, external audits and reviews), as well as government issuances regarding potential risk areas (e.g., CMS scope of work for contractors, OIG’s work plan). Not everything will merit the same attention and not everything can be given attention at the same time. A hospital will screen and triage specific matters and prioritize investigations. The facts will drive its response. Commentary from CMS or OIG about specific areas of interest will inform the self-monitoring priorities a hospital establishes. The proposed rule ignores this context, as well as the fact that many issues will be the result of the errors by CMS or contractors in claims processing rather than billing. **The implication of the proposed rule is that when a hospital learns of an actual overpayment it must pursue and investigate any theoretically possible similar situations. That is unreasonable and not feasible.**

The proposed rule also places an unreasonable emphasis on speed. The proposed rule leaves hospitals open to an FCA allegation of unlawfully retaining an overpayment if it is not returned within 60 days of *receipt*. Hospitals have to balance doing a credible and appropriate investigation against the possibility that a whistleblower will assert they should have known sooner and subject them to the costs and burden of defending a

meritless FCA case. **The proposed rule should not enable meritless FCA cases to be brought against hospitals.**

10-year “Look back.” The effect of the proposed rule’s overreaching duty to investigate any theoretically possible overpayment is exacerbated by its unprecedented expansion from four to 10 years of the period of time a hospital must look back for similar overpayments. The only explanation given for more than doubling the look back period is a desire to match the outside time limit for filing an FCA lawsuit. **The expanded look back is unreasonably burdensome and its retrospective application is legally flawed.**

Expansion of the look back period would create unreasonable burdens for hospitals. Books and records would have to be kept much longer than currently required. This would affect information systems and create additional and competing demands from CMS for investments in information technology. The proposed rule appears to assume that if a button is pushed, 10 years of claims are immediately available (i.e., the current software and systems have been static for 10 years, all data tapes are kept and on site) and that an automated determination can be made of whether an overpayment was received (i.e., what was the controlling guidance at every point in the 10-year period, whether an error was made, and whether, with corrected billing, an overpayment was ultimately received and, if yes, what was the amount).

Hospitals rely on rules like the reopening rule as a benchmark of administrative finality. Under the proposed rule, claims long believed to have been closed and final could be subject to re-opening the day the rule takes effect. Providers have kept their books, planned transactions and issued financial reports in reliance on the fact that those payments were finally closed. Contingencies are planned for periods tied to that finality. The proposed rule would in one stroke subject those claims to possible reopening and could have significant unintended consequences (e.g., limiting a hospital’s ability to get a clean opinion from their financial auditors if the Medicare program keeps the activity open for 10 years for any type of error). That uncertainty is a cost that must be taken into account.

In addition, there is a real possibility that Medicare’s contractors lack the capacity to effectively audit claims that are more than a few years old. Like hospitals, the contractors have operated for many years under a much more limited reopening period and likely do not have the ready access to a comprehensive archive of the program policies, memoranda, coverage decisions and other documentation they would need to carry out a fair and effective evaluation of whether an overpayment was made up to 10 years earlier. **The current reopening rule and look back period should remain unchanged.**

Lastly, as discussed above, the proposed rule will impose tremendous burdens on hospitals. **The proposed rule fails to acknowledge the practical and administrative**

consequences of the new requirements and the “impact analysis” fails to recognize the compliance burden it creates. The impact analysis attempts only a rough estimate of the costs to complete and submit the form for reporting an overpayment. It completely misses the time and resources that would be required to comply with the proposed rule and accurately and reliably obtain the information necessary on which a report of an overpayment is based. There is no serious effort to make a cost/benefit analysis of the proposed rule. **The impact analysis is grossly inadequate to meet the objectives of “quantifying both costs and benefits, of reducing costs, of harmonizing rules, and promoting flexibility” (Executive Order 13563).**

FALSE CLAIMS ACT CONCERNS

Expansion of FCA Liability. The proposed rule attempts to inappropriately expand the reach of the FCA, creating unwarranted legal risk for hospitals. The overpayment provision is not about FCA and it is not about fraud; the overpayment provision is about payments made or received by mistake. Yet the proposed rule’s underpinnings are the FCA. First, it substitutes FCA standards for judging a hospital’s performance (instead of focusing on what a hospital actually knows, it focuses on what a whistleblower or government official later finds the hospital should have known: “failure to make reasonable inquiry, including failure to conduct such inquiry with all deliberate speed...could result in the provider knowingly retaining an overpayment because it acted in reckless disregard or deliberate ignorance of whether it received such an overpayment”). Second, it substitutes the period for bringing an FCA action as the period during which CMS could reopen mistakenly overpaid claims, more than doubling the current timeframe. **The FCA carries extreme penalties to address improper conduct. It is inappropriate and legally flawed to import the FCA into the overpayment rule.**

The proposed rule seeks to expand the FCA to impose penalties for failing to investigate possible overpayments. Its equation of actual knowledge of an overpayment (“identified”) with should have known of an overpayment (acted “in reckless disregard or deliberate ignorance”) is at odds with what Congress intended. In earlier legislative versions of the overpayment provision, the word “knowing” was used (and the definition was linked to the FCA). As is evident in the language passed by Congress, it chose to remove “knowing” and substituted “identified” instead.

The proposed rule seeks to justify use of the FCA terminology by pointing out that a definition of “knowing” is in the final bill. That ignores the more logical explanation that, when knowing was removed as the operative term, there was an incomplete “scrub” of the rest of the bill. Instead of focusing on the significant difference between “identified” and “knowing” and implementing the law accordingly, the proposed rule acts as if the change were of no consequence. **A brief review of the origins of the overpayment provision demonstrates that Congress did not regard “identified” and “knowing” to be interchangeable terms.**

Just 10 months before taking up the ACA overpayment provision, Congress amended the FCA through FERA. In FERA, Congress sought to “correct” the FCA to overcome perceived obstacles to liability for what proponents called “finders-keepers fraud” – fraud that involved hiding money paid by mistake that the recipient actually knew he or she was not entitled to have. To accomplish this goal, Congress expanded the FCA to reach any person who “knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government.” At the same time, the FCA’s definition of “obligation” was amended to include “an established duty . . . arising from . . . the retention of any overpayment.” The FERA amendment expanded FCA liability, but only for overpayments a recipient actually knew he or she had received.

When Congress took up the overpayment provision a year later and sought to establish a timeline for repayment that would create an “established duty” and distinguish proper from improper retention of an overpayment, it obviously did so with the lessons of FERA in mind. The fact that FERA requires proof that a provider retained an overpayment not only “knowingly” but also “*improperly*” and the meaning Congress ascribed to that term is important to understanding the limits of complementary provisions like the overpayment provision in ACA.

Debate on the language and an amendment to FERA by Senator John Kyl made clear that Congress intended not to expose providers to FCA liability for merely receiving an overpayment. Surveying a number of judicial opinions interpreting the phrase “knowingly and improperly,” Senator Kyl concluded that “the words ‘knowingly and improperly’ have a fixed meaning that, at the very least, requires either improper motives or inherently improper means” (Cong. Rec. S4540, April 22, 2009).

Representative Dan Maffei, speaking in favor of FERA on the House floor, offered a similar explanation of the bill’s limited purpose: “One of the things this legislation does is expend [*sic*] that powerful weapon [the FCA] to reach schemes that defraud the government of money it pays by mistake . . . that the entity keeps and maybe hides rather than notifying the government or returning it to the government” (Cong. Rec. H5268, May 6, 2009).

Enacted in the direct wake of FERA, the overpayment provision cannot be read to extend liability for retention of overpayments beyond the bounds Congress had established just 10 months before. Congress specifically chose the word “identified” over the term “knowingly” as the operative provision. Moreover, the two words are used in entirely different ways: “knowing” is used in the FCA as a measure of circumstantial evidence revealing to a fact finder a defendant’s improper intent, while “identified” is used in the overpayment provision to indicate that an overpayment is actually revealed to the recipient. The two terms simply are not interchangeable.

The AHA objects to the proposed rule's equation of having "identified an overpayment" with something less than "actual knowledge." The proposed rule converts a clear statutory concept with definitive limits into an ambiguous duty to investigate, the bounds of which will be subject to litigation for years to come. And because that litigation will proceed under the FCA, the duty will first be interpreted by *qui tam* relators incentivized to push the envelope by contingent rewards and fees. **Congress did not intend to create the risk of litigation and the related expense that will result from the proposed rule.**

10-year Look Back and Retrospective Application. The proposed rule would improperly disturb the balance of Administrative Finality and unlawfully impose retroactive FCA liability. The proposed rule seeks to establish a "look back" period during which the repayment obligation would apply by more than doubling the applicable reopening period from four years to 10 years. The proposed rule justifies this extraordinary step by stating in the preamble that "this is the outer limit of the FCA statute of limitations" and that a 10-year period strikes the "appropriate" balance between giving providers certainty about ongoing liability for past overpayments and ensuring that overpayments are returned to Medicare. The AHA strongly disagrees; extension of the reopening period is far from that simple.

First, there is no reason to align the overpayment provision with the FCA because it is not a fraud provision. The FCA may well be a vehicle to enforce violations of the overpayment provision, but the "outer limit of the FCA statute of limitations" is irrelevant to the administrative process of recouping overpayments.

Second, the statute of limitations under the FCA is not 10 years; it is six years (*see* 31 U.S.C. § 3731(b)(1)).

Third, under current law, claims paid in 2002, 2003, 2004, 2005, 2006 and 2007 are closed and final. They have been audited, reviewed and revisited. They cannot be reopened. The proposed rule would upend these important notions of finality, resurrecting for review and investigation under the FCA years of claims that are today final. The proposed rule amounts to prohibited retroactive rule making, arguably giving rise to an obligation to repay overpayments discovered today if received outside the currently applicable reopening period. It is well-established law that a federal agency cannot impose new duties or liability for already completed transactions and thereby retroactively punish conduct pre-dating the announcement of the standard (*Landgraf v. USI Film Products* (1994)). Claims from 2002-2007 are already completed transactions.