HCCA Compliance Institute
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Exploring CMS’s Final Rule on Reporting and Refunding Overpayments

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Overpayments and Self-Disclosures
The Affordable Care Act Law

- **March 23, 2010**: Enactment of the Affordable Care Act (ACA)

- **Section 6402(a) of the ACA** (now codified at 42 U.S.C. § 1320a-7k(d)):

  - A person who has received an overpayment must report and return the overpayment within either 60 days after the date on which the overpayment was identified or on the date any corresponding cost report is due, whichever is later.

  - The term “overpayment” means any Medicare or Medicaid funds that a person receives or retains to which the person, after applicable reconciliation, is not entitled.

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Timeline of Significant Overpayment Developments

- **March 2010**: ACA requirement for reporting and refunding Medicare and Medicaid overpayments enacted
- **February 2012**: Medicare Parts A/B Proposed Rule
- **January 2014**: Medicare Parts C/D Proposed Rule
- **February 2014**: Medicare Parts A/B Final Rule
- **May 2014**: Medicare Parts C/D Final Rule
- **February 2016**: No Medicaid Proposed Rule to date
- **March 2017**: Final Rule
“Identification” Defined: A/B Final Rule

- Medicare Parts A/B Final Rule: New regulatory definition in 42 C.F.R. § 401.305(a)(2)
  - An overpayment is identified “when the person has, or should have through the exercise of reasonable diligence, determined that the person has received an overpayment and quantified the amount of the overpayment.”
- This definition includes two key concepts:
  1. Concept of reasonable diligence
  2. Quantification

Concept of Reasonable Diligence

- The finalized definition of “identification” incorporates concept of “reasonable diligence.”
- In the Final Rule, CMS stated that reasonable diligence includes both proactive compliance activities and reactive investigative activities.
  - Size and scope of compliance programs will vary, but having no compliance activities may expose the provider to liability.
- When does the 60-day clock begin to tick?
  1. When the exercise of reasonable diligence is completed, or
  2. If there is a failure to exercise reasonable diligence, on the day when the person received credible information of a potential overpayment.
Credible Information of Potential Overpayments

• Keyword—Potential Overpayments.
• Receipt of “credible information” triggers a duty to investigate.
  • “Credible information” is not specifically defined, but includes information that “supports a reasonable belief that an overpayment may have been received.”
  • CMS specifically rejected an evidentiary standard—instead adopted credible “information” standard.

Potential Sources of “Credible” Information (Not Exhaustive)
Medicare Parts A/B Overpayment Final Rule: Timeline

Final Rule’s General Timeframes for Reporting and Returning Medicare A and B Overpayments

<table>
<thead>
<tr>
<th>Event</th>
<th>Timeframe</th>
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<tbody>
<tr>
<td>Receipt of “Credible Information” of a Potential Overpayment</td>
<td>No More than 6 Months to Investigate and Quantify Potential Overpayments (absent “extraordinary circumstances”)</td>
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<tr>
<td>I--Triggers Duty to Investigate I</td>
<td>60 days to report and return the Overpayments</td>
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<td>Unless “Extraordinary Circumstances,” No More Than 8 Months to Investigate and Report and Refund Medicare Parts A and B Overpayments</td>
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Lookback Period

- Pursuant to the Medicare Parts A/B Final Rule, Medicare Parts A/B overpayments must be reported and returned “only if a person identifies the overpayment within six years of the date the overpayment was received.”

- **Maximum Threshold** - providers should not be foreclosed from using a more limited lookback period if justified by the relevant circumstances (coverage change or EHR system conversion).

- Practical challenges of lookback period:
  - Recordkeeping difficulties
  - Evolving regulatory standards
  - Audit resources
  - Potential need for statistical sampling resources
FCA Enforcement of 60-Day Rule

  - Healthcare provider erroneously submitted claims to Medicaid for payment due to a software error. The provider failed to fully investigate and identify all overpayments until two years later.
  - The court interpreted “identification” to include situations where “a person is put on notice that a certain claim may have been overpaid.”
- Parties settled for **$2.95 million** on August 23, 2016

Retained Overpayments

- *U.S. ex rel. Odumosu v. Pediatric Servs. of Am. Healthcare (PSA); U.S. ex rel. McCray v. PSA*
  - Home healthcare provider to pay $6.88 M to settle allegations that it failed to refund overpayments from TRICARE and 20 state Medicaid programs between 2007 and 2013
  - “First of its kind” settlement stemming from a provider’s failure to “actively investigate whether they have received overpayments and, if so, promptly return the overpayments”
  
  John Horn, U.S. Attorney  
  Northern District of Georgia  
  (Aug. 4, 2015)
  
Questions

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