CMS Finalizes New Medicare Overpayment Rules

New Regulations Create Additional Burdens for Providers, and Noncompliance Can Give Rise to "Reverse False Claim" Liability

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In February, the Centers for Medicare & Medicaid Services (CMS) finalized long-awaited rules implementing the Affordable Care Act's (ACA's) requirement that Medicare providers and suppliers return overpayments within 60 days of discovery.

The final rule creates some flexibility for providers and suppliers to first investigate and calculate overpayments, and it does not include all the requirements that industry had feared. Nevertheless, the rule makes clear that CMS expects providers and suppliers to implement robust compliance regimes to proactively identify overpayments, and it expects providers and suppliers to promptly investigate all credible overpayment allegations. Failure to comply with these requirements may give rise to CMS-imposed penalties, as well as potential liability for a "reverse false claim."

Statutory Background

The ACA included a number of provisions designed to enhance the federal government's ability to discover and prosecute fraud, waste, and abuse in the Medicare and Medicaid programs. Section 6402 of the ACA added a new subsection 1128J(d) to the Social Security Act to require a "person" to report and return any Medicaid and Medicare "overpayment" "by the later of—(A) the date which is 60 days after the date on which the overpayment was identified; or (B) the date any corresponding cost report is due, if applicable."[1] "Person[s]" to whom this 60-day repayment rule applies include Medicaid or Medicare providers and suppliers; Medicaid managed care organizations (MCOs); Medicare Advantage organizations; and Medicare Part D Prescription Drug Plan (PDP) sponsors.[2]

If a "person" fails to return and report an overpayment within 60 days, the person may be subject to a civil monetary penalty and/or exclusion from federal health care programs.[3] In addition, the retention of the overpayment beyond 60 days becomes an "obligation" under the False Claims Act (FCA).[4]

The Final Regulations

In light of differences that exist in the programs, CMS is implementing subsection 1128J(d) through three separate rules: one for Medicare Parts A and B; one for Medicare Parts C and D; and one for Medicaid.[5]

On February 12, 2016, CMS finalized the rule implementing subsection 1128J(d) for Medicare Part A and Part B.[6] (The rule for Medicare Parts C and D was finalized in 2014,[7] and the rule for Medicaid has not yet been promulgated.)

Consistent with subsection 1128J(d), the final rule specifies that a person who has received an overpayment must report and return it by the later of 60 days after the date on which the overpayment is identified or the date any corresponding cost report is due.[8] As in the statute, CMS defines "overpayment" broadly, as "any funds that a person has received or retained under title XVIII of the [Social Security Act] to which the person, after applicable reconciliation, is not entitled under such title."[9] The regulatory obligation to report and return an overpayment exists regardless of whether that overpayment resulted from intentional or unintentional conduct. In addition, in the preamble to the final rule, CMS makes clear that it believes "overpayment" includes "claims resulting from Anti-Kickback Statute or physician self-referral law violations or claims for items and services furnished by an excluded person," as such claims are "specifically not payable" under the Medicare statute.[10]

The final rule also includes several important clarifications and requirements that are not expressly contained in the statute.

Determining When an Overpayment Is "Identified"

As described above, subsection 1128J(d) requires that overpayments be returned within 60 days of being "identified," but the statute does not define the term "identified." The regulation clarifies this point, specifying that identification occurs 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. A person should have determined that the person received an overpayment and quantified the amount of the overpayment if the person fails to exercise reasonable diligence and the person in fact received an overpayment.[11]

There are two particularly noteworthy aspects of this description of "identification" of an overpayment.

First, an overpayment is not "identified" until the provider or supplier has "quantified the amount of the overpayment." This ensures that providers and suppliers have sufficient time to fully investigate and calculate an overpayment, before the 60-day clock begins to run. In the preamble, CMS makes clear that providers and suppliers may "quantify" the amount of an overpayment using statistical sampling and extrapolation, or "other methodologies as appropriate."[12] That is, suppliers and providers need not quantify the precise amount of the overpayment if doing so is excessively burdensome; instead, they can sample their claims and extrapolate, or use "other methodologies as appropriate," to estimate the amount of the overpayment.

Second, the description of "identification" of an overpayment requires providers and suppliers to exercise "reasonable diligence" in determining whether an overpayment has been made and in quantifying the overpayment. In the preamble, CMS explains that "reasonable diligence" means "both [1] proactive compliance activities conducted in good faith by qualified individuals to monitor for the receipt of overpayments and [2] investigations conducted in good faith and in a timely manner by qualified individuals in response to obtaining credible information of a potential overpayment."[13] CMS expects providers and suppliers to conduct and complete investigations "at most 6 months from receipt of the credible information [of an overpayment], except in extraordinary circumstances."[14] "Extraordinary circumstances" include "unusually complex investigations that the provider or supplier reasonably anticipates will require more than six months to investigate, such as physician self-referral law violations that are referred to the CMS Voluntary Self-Referral Disclosure Protocol," as well as "natural disasters or a state of emergency."[15]

In the preamble, CMS indicates that, when a provider or supplier finds a single overpayment, it should "inquire further to determine whether there are more overpayments on the same issue before reporting and returning the overpaid claim."[16] That is, providers and suppliers should identify and quantify all related overpayments to report and return together, which CMS believes generally can be done in six months, except in "extraordinary circumstances."[17]

Six-Year Lookback Period

The final rule includes a "lookback period" of six years. This means that a provider or supplier is obligated to report and return overpayments, consistent with subsection 1128J(d) and its implementing regulations, if it identifies an overpayment within six years "of the date the overpayment was received."[18] If an overpayment is identified more than six years after the date on which it was received, the provider or supplier is not required to report or return it.

This six-year lookback period is substantially less burdensome than the ten-year lookback CMS originally included in the proposed rule. Though welcomed by providers and suppliers, this shortening of the lookback period was not altogether surprising, given the significant pushback CMS received on the ten-year proposal and CMS' subsequent decision to finalize the overpayment regulations for Medicare Parts C and D with a six-year lookback period.[19]

Failure to comply with these requirements may give rise to CMS-imposed penalties, as well as potential liability for a "reverse false claim."

However, even the shorter, six-year lookback period may create significant burdens for providers and suppliers, particularly in light of CMS' instruction that, when an overpayment is identified, providers and suppliers must "inquire further to determine whether there are more overpayments on the same issue before reporting and returning the overpaid claim."[20]

Circumstances Warranting Suspension of the 60-Day Deadline

The final rule describes three circumstances in which the 60-day deadline for returning overpayments will be suspended. The first two of these circumstances are:

(i) OIG acknowledges receipt of a submission to the OIG Self-Disclosure Protocol and will remain suspended until such time as a settlement agreement is entered, the person withdraws from the OIG Self-Disclosure Protocol, or the person is removed from the OIG Self-Disclosure Protocol.

(ii) CMS acknowledges receipt of a submission to the CMS Voluntary Self-Referral Disclosure Protocol and will remain suspended until such time as a settlement agreement is entered, the person withdraws from the CMS Voluntary Self-Referral Disclosure Protocol, or the person is removed from the CMS Voluntary Self-Referral Disclosure Protocol.[21]

That is, the 60-day repayment clock tolls from the time CMS acknowledges receipt of a self-disclosure protocol until: the provider or supplier reaches a settlement agreement with CMS about the information being disclosed, or the provider or supplier withdraws or is removed from the self-disclosure protocol. If a provider or supplier reaches a settlement agreement with CMS through a self-disclosure protocol, it is deemed to have satisfied subsection 1128J(d)'s requirement with respect to the reporting and return of the overpayment(s) at issue.[22]

[A]n overpayment is not "identified" until the provider or supplier has "quantified the amount of the overpayment."

The third circumstances in which the 60-day repayment deadline will be suspended is when a provider or supplier requests an extended repayment schedule under 42 C.F.R. § 401.603.[23] The deadline "will remain suspended until such time as CMS or one of its contractors rejects the extended repayment schedule request or the provider or supplier fails to comply with the terms of the extended repayment schedule."[24]

Potential FCA Liability

Health care providers and suppliers that submit false claims to the government can face significant sanctions under the FCA: civil penalties of between $5,500 and $11,000 for each false claim, plus treble damages.[25]

Subsection 1128J(d) expressly contemplates the possibility of enforcement through the FCA. Specifically, subsection 1128J(d)(3) provides that an "overpayment" that is "retained . . . after the deadline for returning and reporting the overpayment" constitutes an "obligation" for purposes of the FCA. The FCA, in turn, imposes liability on one who "knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government."[26] This provision is commonly referred to as the "reverse false claims" provision, because instead of addressing false or fraudulent claims for payment *by* the government, it prohibits a failure to make payments *to* the government when required to do so.

As the language of the "reverse false claims" provision suggests, it may be implicated by intentional conduct undertaken to improperly avoid repayment, conceal the retention of an overpayment, or wrongfully reduce the amount thereof. In addition, the intentional creation of false records or statements that are "material" to the retention of an overpayment may give rise to liability. For these purposes, the term "material" is defined broadly to include any conduct "having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property."[27] A violation of the FCA requires conduct that is undertaken "knowingly"; unintentional, accidental, or merely negligent acts are outside the scope of the statute. Under the "reverse false claims" provision, the conduct must be undertaken "knowingly and improperly." Courts have not addressed the meaning of the term "improperly" in the FCA, but the legislative history indicates that liability should be limited to overpayments retained in bad faith.[28]

In addition to the reverse false claims provision, another potentially relevant subsection of the FCA is 31 U.S.C. § 3729(a)(1)(D). This provision creates liability where one "has possession, custody, or control of property or money used, or to be used, by the Government and knowingly delivers, or causes to be delivered, less than all of that money or property." Although this provision may not apply to the retention of an overpayment because, among other things, the overpayment would not necessarily be money "used, or to be used," by the government, claims under subsection 3729(a)(1)(D) have not been litigated frequently. C

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Endnotes

1 Social Security Act (SSA) § 1128J(d), 42 U.S.C. § 1320a-7k(d).
2 *Id.* § 1128J(d)(4)(C).
3 *See* SSA § 1128A(a)(10), 42 U.S.C. § 1320a–7a(a)(10).
4 SSA § 1128J(d)(3).
5 81 Fed. Reg. 7654, 7655 (Feb. 12, 2016).
6 *Id.* at 7654.
7 79 Fed. Reg. 29844 (May 23, 2014).
8 42 C.F.R. § 401.305(b)(1).
9 42 C.F.R. § 401.303.
10 81 Fed. Reg. at 7658.
11 § 401.305(a)(2).
12 81 Fed. Reg. at 7661.
13 *Id.*
14 *Id.* at 7662.
15 *Id.*
16 *Id.* at 7663.
17 *See id.* at 7664.
18 42 C.F.R. § 401.305(f).
19 42 C.F.R. §§ 422.326(f), 423.360(f).
20 81 Fed. Reg. at 7663.
21 § 401.305(b)(2).
22 *Id.* § 401.305(d)(2).
23 *Id.* § 401.305(b)(2).
24 *Id.*
25 31 U.S.C. § 3729(a)(1)(G).
26 *Id.*
27 § 3729(b)(4).
28 *See* 155 Cong. Rec. S.4540 (daily ed. Apr. 22, 2009) (statement of Sen. Kyl) ("in the FCA context . . .'improper means' must be means that are *malum in se*—that is, means that are inherently wrongful and constitute an independent tort").