Association of
American Medical Colleges
2450 N Street, N.W., Washington, D.C. 20037-1127
T 202 828 0400 F 202 828 1125
www.aamc.org

Submitted electronically at www.regulations.gov

April 16, 2012

Marilyn B. Tavenner
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

RE: Medicare Program; Reporting and Returning of Overpayments, CMS-6037-P

Dear Acting Administrator Tavenner:

The Association of American Medical Colleges (AAMC) welcomes this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS's or the Agency's) proposed rule entitled "Medicare Program; Reporting and Returning of Overpayments, 77 Fed Reg 9179, February 16, 2012. The Association represents nearly 300 general acute nonfederal major teaching hospitals and health systems; all 137 accredited U.S. medical schools; 94 professional and academic societies; 90,000 full-time clinical faculty; and the nation's medical students and residents.

AAMC members recognize that any overpayment must be returned, and they expend considerable time and money ensuring that bills submitted to Medicare and payments received are correct. This is the same standard that is used for all payers. They also are subjected to a continuous barrage of Medicare and Medicaid audits from MACs, RACs, and numerous other contractors. The AAMC is very concerned that the proposed rule is overreaching, would be extremely burdensome to providers without having a commensurate benefit to the Medicare program, and would deny providers the ability to exercise due diligence by investigating potential overpayments to determine whether they are, in fact, overpayments. Our concerns, as well as revisions that we think are necessary for the final rule, are described in more detail below.

Not every incorrect payment is an overpayment

Identifying a claims-based overpayment

Section 6402(d) (1) of the Affordable Care Act (ACA) requires that:
An overpayment must be reported and returned under paragraph (1) by the later of –

(A) The date which is 60 days after the date on which the overpayment was **identified.**

A key to implementing this provision is to determine when an overpayment is "identified." Language in the preamble suggests that it may be CMS's intent to allow providers time to "exercise due diligence to determine whether an overpayment exists." (77 Fed Reg. 9182). However, the regulatory language fails to reflect that this is the case, leading to a need for CMS to issue adequate guidance to avoid confusion about when the 60 day clock begins—from the moment of discovery of a potential overpayment or, as should be the case, from the time when the provider confirms that an overpayment exists. Therefore, the AAMC requests that CMS include in the regulatory language that:

- A "person has actual knowledge of the existence of the overpayment" after due diligence has been exercised to confirm that the overpayment exists.

This revision will require guidance regarding the exercise of due diligence. Concern that some providers may take overly long to exercise due diligence, could be addressed by limiting the amount of time allowed to confirm an overpayment. Yet, rather than using an arbitrary, one-size-fits-all time limit, the time should vary depending on whether the error represents a pattern of problems over a period of time or is a one-time problem related to a single evaluation and management service. In addition, a thorough review requires allowing for an opportunity to hold a closing conference between the auditor and provider, a standard practice.

For cost report overpayments, the 60-day clock should begin when the report is reconciled or, in the case of appeals, when all appeals are exhausted

The ACA also requires that the "overpayment must be reported and returned . . . by the later of . . . the date any corresponding cost report is due, if applicable" (Section 6402(d) (1)(B) of the Affordable Care Act (ACA). The proposed rule takes the approach that the cost report is due on the date of filing. However, doing so does not take into account audit adjustments which occur after filing and could identify a previously undiscovered overpayment (or underpayment), thus creating a situation in CMS could claim that the overpayment was not returned within 60-days. For example, on audit resident counts for direct graduate medical education (DGME) and indirect medical education (IME) payments are reconciled after the cost report is filed, and the reconciliation could result in an overpayment. There also is the possibility, especially with DGME and IME, that disagreements about the resident counts may result in an appeal to the Provider Reimbursement Review Board, and perhaps to Federal court. The AAMC urges CMS to take an expansive approach to overpayments related to cost reports that will not disadvantage providers and be clear that such actions will toll the 60-day clock. In the event that the reconciliation does not result in an appeal, the final rule should state that if an overpayment is identified at the time of the reconciliation, the 60-day clock begins at that time, not on the date when the cost report is filed.

Routine Adjustments Should Not Trigger the Overpayment Process

The AAMC requests that CMS state that a routine adjustment does not trigger an overpayment process, and therefore does not start the 60-day clock; to do otherwise will become a disincentive for conducting routine audits which now are considered to be part of good business practices. These adjustments are identified during routine monitoring of coding, billing and claims processing practices and are:

- Part of normal business processes (monitoring)
- Random events that affect a single claim or handful of claims rather than a universe of claims
- Reported and repaid via adjustment in Fiscal Intermediary Shared System

The lookback period should be consistent with Medicare record retention requirements, applied in a reasonable way, and take into account the usefulness of information from previous years

The 10 year lookback period derives from the Federal False Claims Act and relates to the longest period of time for a *qui tam* action to be filed. Overpayments are the result of errors and clearly should not be equated with fraudulent activity, nor be subjected to the same standard. The 10 year lookback also is inconsistent with the Medicare requirements that allows a 4 year period for reopening a claim. Rather than creating a new and burdensome standard, CMS should be harmonizing the overpayment lookback period with existing Medicare requirements.

Finally, record retention requirements of states differ but, except in the case of minors, generally are less than 10 years. 42 CFR 482.24 (b) (1) requires hospitals to maintain medical records in their originally and legally reproduced form for a period of at least 5 years but other than this they are subject to individual state standards. The availability of records could very well differ from state to state and could thereby create difficulties in obtaining documentation in one state that may not be encountered in another. The proposed rule also fails to consider that during a 10-year period a hospital or physician practice may have changed its billing systems, making it exceedingly difficult to validate findings from many years ago.

Finally, imposing a single 10-year lookback period in every case would drastically increase the size of an audit universe (even if statistical sampling methodology applied), even when the facts clearly do not warrant it. For example:

- If a routine compliance audit of 3 months of billing uncovers a single error that resulted in an overpayment, it should not be necessary to undertake a 10-year lookback.
- A national coverage decision (NCD) or local coverage decision (LCD) was issued 2 years ago. An audit is conducted and an overpayment is discovered that relates

to the NCD or LCD. In this case, there is no need to go back beyond the 2 years when the NCD or LCD was issued

As proposed, the 10-year lookback would apply equally to every overpayment, causing an extreme and unnecessary burden on providers. Therefore, the AAMC urges CMS to not finalize a 10-year lookback period for overpayments, and to include the following provisions in the final rule:

- Limit the lookback to 4 years;
- Limit the investigation of an overpayment back to a point in time when no evidence of incorrect billing exists.
- Allow underpayments that are identified to be netted against overpayments when determining the repayment amount.

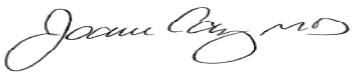
Other Issues

The AAMC has the following additional comments:

- A disclosure under the CMS self-disclosure protocol should toll the 60-day deadline.
- Given the extensive reviews and audits to which hospitals and physicians are subject, the rule should not apply to any claims or issues that are the subject of any government review.

Please direct any questions to Ivy Baer of my staff, ibaer@aamc.org or 202-828-0499.

Sincerely,



Joanne M. Conroy, M.D.
Chief, Health Care Officer

cc: Ivy Baer, JD