Identified!: Understanding the New Overpayment Refund and Disclosure Rules

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Treatment of Overpayments Under PPACA

- PPACA generally expands coverage. How to pay for it?
- Pres. Obama: “We've estimated that most of this [health care reform] plan can be paid for by finding savings within the existing health care system, a system that is currently full of waste and abuse.”
- FCA and qui tam provisions seen as incredibly effective revenue generator.
Treatment of Overpayments Under PPACA

- Several key open issues
- No CMS regulations or DOJ statements
- NYS OMIG has provided public commentary on 7/14/2010 (Bastille Day)
  - Very aggressive interpretation
  - Significantly restricts provider flexibility
  - Only “applicable” in NY Medicaid, but NYS OMIG is a visible pulpit
Background on Treatment of Overpayments

- Historically, no express duty to refund innocent overpayments (arguable on Part A)
- DOJ/CMS disagrees
- The FCA contains a provision for “reduced damages” (reduced to 2X damages) if a court finds that:
  - (A) the violator furnished the government “all information known to such person about the violation within 30 days after the date on which the defendant first obtained the information;
  - (B) such person fully cooperated with any Government investigation of such violation; and
  - (C) at the time such person furnished the United States with the information about the violation, no criminal prosecution, civil action, or administrative action had commenced under this title with respect to such violation, and the person did not have actual knowledge of the existence of an investigation into such violation
2009 Fraud Enforcement and Recovery Act (FERA) Changes

- May 20, 2009 FERA expressly referenced improper retention of "obligations"
- Broadened the definition of a false claim to include the situation where a person “knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the government . . . .”
2010 PPACA Changes

1. Civil Monetary Penalties Law
   - Failing to report and return known overpayment within 60 days/or when cost report due (such failure is also subject to potential FCA liability)
   - This provision was less noticed . . . but related . . .

2. False Claims Act Provision
   - PPACA § 6402(a): Express duty to refund and report Medicare and Medicaid overpayments
   - By *the later* of 60 days after overpayment “identified” or the date cost report is due
   - Failure to report and return is an “obligation” for the purpose of FCA
How does a compliance officer apply this new law?

Let’s unpack the key principles:

– What is an “overpayment”?  
– When is it “identified”?  
– What is the provider’s actual duty?  
– What is the timeframe for returning and disclosing overpayments?
What does the law actually say?

“(d) REPORTING AND RETURNING OF OVERPAYMENTS.—

“(1) IN GENERAL.—If a person has received an overpayment, the person shall—

“(A) report and return the overpayment to the Secretary, the State, an intermediary, a carrier, or a contractor, as appropriate, at the correct address; and

“(B) notify the Secretary, State, intermediary, carrier, or contractor to whom the overpayment was returned in writing of the reason for the overpayment.

“(2) DEADLINE FOR REPORTING AND RETURNING OVERPAYMENTS.—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; or

“(B) the date any corresponding cost report is due, if applicable.
What does the law actually say?

“(3) ENFORCEMENT — Any overpayment retained by a person after the deadline for reporting and returning the overpayment under paragraph (2) is an obligation (as defined in section 3729(b)(3) of title 31, United States Code) for purposes of section 3729 of such title.

“(4) DEFINITIONS.—In this subsection:

“(A) KNOWING AND KNOWINGLY.—The terms ‘knowing’ and ‘knowingly’ have the meaning given those terms in section 3729(b) of title 31, United States Code.

“(B) OVERPAYMENT.—The term “overpayment” means any funds that a person receives or retains under title XVIII or XIX to which the person, after applicable reconciliation, is not entitled under such title.

“(C) PERSON.—

“(i) IN GENERAL.—The term ‘person’ means a provider of services, supplier, medicaid managed care organization (as defined in section 1903(m)(1)(A)), Medicare Advantage organization (as defined in section 1859(a)(1)), or PDP sponsor (as defined in section 1860D–41(a)(13)).

“(ii) EXCLUSION.—Such term does not include a beneficiary.
What does the law actually say?

- No definition of “not entitled”
- No definition of “after reconciliation”
- No explanation of when the “cost report” deadline applies
- No definition of “identified”

- These open questions are the key sources of confusion in the industry
What is “not entitled”?

- Probably the same analysis of overpayments as providers historically used . . . condition of payment not met
- NYS OMIG:
  - AKS
  - Stark
  - Beneficiary eligibility
  - Conditions of payment
What is “after reconciliation”?

Possibilities:
- Calculating copay/deductibles
- Running through cost report
- Calculating actual reimbursement impact
- Offsetting underpayments
- Interim payments vs. final settled payments

NYS OMIG:
- Applies to interim payments prior to cost report-based payment determinations
- Reconciliations related to Medicaid best price determinations for prescription drugs
- CMS 838 – quarterly report of Medicare credit balances

Providers will view this principle as contemplating mathematical calculations to arrive at the precise financial impact of the overpayment
When does the “cost report” deadline apply

- Is it only for interim payments that don’t get resolved through the cost report?
- Could it apply to all cost-reporting providers, and use the “attachment package” to report and refund overpayments?
What does it mean to “identify” an overpayment?

- Not defined in the Statute
- Possibilities range from:
  1. Any whiff of an overpayment with no clue of whether it is accurate
  2. Awareness that an overpayment has been received, but no knowledge of how much has been overpaid
  3. Confidence that an overpayment has been received, and the amount of the overpayment has been determined using commercially-reasonable methods and a responsible process
  4. To moral certainty that an overpayment has been received, with no possible defenses or counterarguments and an absolute certainty of the amount of the overpayment.
What does it mean to “identify” an overpayment?

- NYS OMIG took extremely hard line:
  - “identified” means that “the fact of an overpayment, not the amount of the overpayment has been identified. (e.g., patient was dead at time service was allegedly rendered, APG claim includes service not rendered, charge master had code crosswalk error)”

- OMIG draws comparison with language from CMS proposed 42 CFR 401.310 overpayment regulation 67 Fed. Reg. 3665 (1/25/02 draft later withdrawn) “If a provider, supplier, or individual identifies a Medicare payment received in excess of amounts payable under the Medicare statute and regulations, the provider, supplier, or individual must, within 60 days of identifying or learning of the excess payment, return the overpayment to the appropriate intermediary or carrier.”

- Opposite conclusion could be made from the fact that CMS included “identifying or learning of”
What does it mean to “identify” an overpayment?

- **NYS OMIG examples**
  - Employee or contractor identifies overpayment in hotline call or email
  - Patient advises that service not received
  - RAC advises that dual eligible Medicare overpayment has been found
  - OMIG sends letter re deceased patient, unlicensed or excluded employee or ordering physician
  - *Qui tam* or government lawsuit allegations
  - Criminal indictment or information

- In all of these examples, provider doesn’t know (1) if the overpayment allegation is accurate or (2) the amount of any overpayment
What does it mean to “identify” an overpayment?

- Impact:
  - Under NYS OMIG interpretation, provider only has a 60 day window from first allegation of a problem (the “whiff rule”) to making the refund and disclosure
  - Maybe there is a duty to refund an overpayment before knowing how much needs to be refunded – how can this be done?
  - Does CMS expect some escrowed payment? Or a payment well in excess of any possible overpayment?
  - Complaints and indictments trigger refund duty?
  - Criminal complaint? Does that require waiving 5th Amendment protections?
How should providers respond?

- May be impossible to complete an investigation within 60 days after the first allegations.
- If duty is not merely to disclose a problem, but also to make a “refund” “after reconciliation,” then it is reasonable that there is a right to properly investigate the allegations.
- Courts are unlikely to allow providers to drag on investigations indefinitely.
- One possible standard is when the company possesses “credible evidence” that it is “probable” that it has received an overpayment and thus is obligated to return the monies to the government.
- Establish a work plan with short time-lines to reach acceptable level of knowledge.
Questions and Answers

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