April 16, 2012

Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Via Online Submission

Re: CMS-6037-P Reporting and Returning Medicare Overpayments

Dear Ms. Tavenner:

On behalf of the Ambulatory Surgery Center Association (ASCA), representing the interests of the nation's 5,300 ASCs, I am thankful for the opportunity to provide comments on the agency's proposed rule concerning reporting and returning of overpayments (CMS-6037-P, 77 FR 9179) "Proposed Rule." As you are aware, ASCs provide high quality efficient care to Medicare beneficiaries across the country. Because ASCs are typically small business they are particularly adversely affected by burdensome regulations. In particular, the proposed rule raises the following concerns.

1. ASCs represent a low risk for erroneous payments and should not be subjected to the same requirements as providers/suppliers that represent a higher risk.
In the Proposed Rule, CMS applies one size fits all requirements to ASCs despite the fact that ASCs represent a relatively low risk of erroneous payments. CMS classifies ASCs as representing limited fraud risk.[1] Additionally, ASC billing is relatively less complex and thus less subject to errors than other types of providers. For example, ASCs do not rely on cost reports to reconcile their charges. CMS should tailor the obligations pertaining to ASCs identifying improper payments based on the limited level of risk that ASCs provide.

2. CMS should make clear that an overpayment exists only where a provider/supplier receives a payment they are not entitled to receive *at the time of payment.*
The Proposed Rule defines "overpayment" as "any funds that a person receives or retains under title XVII . . . to which the person, after applicable reconciliation, is not entitled under such title."[2] CMS should revise this definition to make it clear that an overpayment exists only where a provider was not entitled to the payment at the time the payment was made. Subsequent changes in law, policy or circumstances should not render payments that were proper at the time they were made overpayments at a later date.

[1] See, for example, 77 FR 5868
[2] Proposed 42 C.F.R. § 401.303.

3. CMS should establish a minimum threshold for what constitutes an overpayment triggering an obligation to return money.

The Proposed Rule does not set a threshold as to what amount of money constitutes an "overpayment." In some circumstances, providers/suppliers receive trivial overpayments of a few dollars or even less than a dollar. It would inequitable to subject providers/suppliers to CMP liability and possible exclusion from participation in federal health care programs in such situations.

4. Using the False Claim Act's expansive definition of the term "knowing" to establish when an overpayment was identified is inappropriate, arbitrary and capricious.

The Proposed Rule provides that a supplier/provider has "identified" an overpayment not only if the provider/supplier has actual knowledge of the existence of the overpayment but also if the provider/supplier *acts in reckless disregard or deliberate ignorance of the existence of the overpayment."*[3] In doing so CMS applies the False Claims Act's "knowledge" standard in specifying when an overpayment is "identified."

This is entirely inappropriate. The False Claims Act was designed to impose liability on those that defraud the federal government. In contrast, the Proposed Rule is concerned with catching overpayments that are a result of simple error. Applying a broad measure of intent meant to catch fraud to impose liability for simple errors is unfair and inappropriate. Moreover, there is no clear statutory basis to support such a broad standard of "identified." Just because the ACA in general defines "knowing" as having the False Claim Act's definition of that term, it does not mean that it was also Congress' intent to apply the same False Claims Act knowledge standard to the identification of overpayment that are a result of simple error.[4]

5. The obligation to affirmatively investigate evidence of overpayments is overly broad and creates an undue burden.

The proposed rule requires that health care providers/suppliers take affirmative steps to investigate evidence of overpayments. The Proposed Rule is ambiguous in explaining what evidence triggers an obligation to investigate. For example, the Proposed Rules indicates that there is an obligation to investigate where "a provider of services or supplier reviews billing or payment records and learns that it incorrectly coded certain services resulting in increased reimbursement" but is unclear how far the duty to investigate extends in this circumstance. For instance would an ASC have a duty to merely investigate the indentified overpayments arising from the specific instances of miscoding or would the ASC have an affirmative duty to more broadly audit similar claims processed by the biller in error?

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[3] Proposed 42 C.F.R. § 401.305(a)(2).

[4] In fact, the application of the FCA knowledge standard to the identification of overpayments was removed from a previous version of the ACA evincing the Congressional intent *not* to equate the False Claims Act's knowledge standard with the intent standard of identifying overpayments.

Additionally, the examples offered in the preamble suggest that providers/suppliers have a duty to investigate when there is even a specter of impropriety. For example, the proposed rule notes that there is a duty to investigate when a provider/supplier receives an anonymous telephone tip, regardless of its degree of substantiation.

Such ambiguous and broad duties to investigate will create confusion and undue burden as ASCs and other providers/suppliers seek to avoid the extreme penalties imposed for violations of the False Claims Act. CMS should revisit the obligations to investigate and provide a more precise pronouncement of the duty as well as tailoring the obligation more narrowly.

7. The 10 year look back period is arbitrary and overreaching.

The Proposed Rule arbitrarily adopts the outer most limit of the False Claims Act's statute of limitations in establishing a ten year look back period for overpayments. The basic statute of limitations under the False Claim Act is six years. The extended ten year statute of limitation was put in place to afford the government additional time to file suit where they learn of a violation late in the process. It should be noted, however, that the government only has three years to bring suit after learning of the violation (extending the maximum time period to up to ten years from when the violation actually occurred). Adopting a the maximum statute of limitations, which was designed to operate in limited circumstances, of the False Claims Act as the general look back period for identifying overpayments imposes an undue burden on providers/suppliers.

Even more troubling, the proposal would amend the reopening rules at 42 CFR § 405.980(b) to provided that overpayments may be reopened by the government for a period of 10 years. This is an extreme an unwarranted expansion of government power. Currently, claims may only be opened after one year for good cause and only after four years on evidence of fraud. If the Proposed Rule change is finalized, claims could be opened for any reason for a period of ten years. ASCs have relied on these longstanding rules to establish a sense of finality and predictability in their Medicare payments. The proposal would turn this certainty on its ear and raises issues of fairness as ASCs and other healthcare providers/suppliers would be forced to defend allegations of ten year old overpayments.

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Thank you for the opportunity to offer these comments. If ASCA may provide any additional information, or to set up a meeting with representatives of the ASC community, please contact Jonathan Beal at jbeal@ascassociation.org or 202.487.0941.

Sincerely,

William Prentice
Executive Director
ASCA