CALIFORNIA HOSPITAL ASSOCIATION
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April 13, 2012

Ms. Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-6037-P
7500 Security Blvd.
Baltimore, MD 21244-1850

Submitted Electronically via www.regulations.gov

Subject: CMS-6037-P: Medicare Program Proposed Rule Regarding Reporting and Returning of Overpayments

Dear Ms. Tavenner:

On behalf of our nearly 400 member hospitals and health systems, the California Hospital Association (CHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule that would require a provider or supplier that has received an overpayment from Medicare to report and return the overpayment within the later of 60 days of "identification" of the overpayment or the date any corresponding cost report is due, if applicable. This proposed rule seeks to implement Section 6402(a) of the Patient Protection and Affordable Care Act of 2010 (ACA).

As you know, the overpayment provision was enacted in the ACA as a result of expansions to the False Claims Act (FCA) in the Fraud Enforcement and Recovery Act of 2009 (FERA). In FERA, Congress made "retention of an overpayment" a basis for FCA liability. It was added in response to concerns that a contractor or other recipient of federal funds would recognize an overpayment had occurred and either not return the funds or significantly delay a return to reap further unearned financial benefit. As a result, anyone who "knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government" is subject to FCA liability. The term "obligation" is defined to include a duty "arising from the retention of an overpayment." Prior to enacting the overpayment provision in the ACA, there was no explicit statutory obligation in the Social Security Act to return overpayments from the Medicare and Medicaid programs. The purpose of this provision was to fill that gap.

CHA believes that in proposing this regulation, CMS has gone far beyond the legislative intent of Congress in addressing this current gap in the statue. As drafted, the proposed regulation is fraught with vague terms that if left unaddressed will create significant unintended consequences for providers and add increased administrative burden and complexity on top of an already complicated set of billing and disclosure requirements across both the Medicare and Medicaid programs. The proposed rule presents several significant operational, technical and legal issues that must be addressed. CHA urges CMS to give careful consideration to our detailed comments below and to move swiftly to work with colleagues across agencies to make these important and necessary changes.

Scope of Proposed Rule Must Be Refined: Definition of "Person"

The ACA defines the term "person" as a provider of services, supplier, Medicaid managed care organization, Medicare Advantage organization, or PDP sponsor. The proposed rule, however, is limited in scope, applying only to Medicare Part A and Part B providers and suppliers. CMS does not articulate

any statutory authority or rationale for creating this distinction and narrowing the scope of the proposed rule to Medicare Part A and Part B providers and suppliers. Rather, CMS states that all stakeholders are still subject to the statutory requirements to report and repay overpayments. Since the Medicare payment rules do not create any analytically distinct issues for Medicare Part A and Part B providers and suppliers over other categories of "persons" as defined under the proposed rule, CHA believes that the proposed rule should similarly apply equally to all categories of "persons" as they relate to Medicare. **Therefore, CHA urges CMS to revise the proposed rules for Medicare to make applicable to person(s) as defined under the ACA.**

While there is no functional difference for this purpose in the context of Medicare, Medicaid is a program principally administered by the states with broad federal guidance. The proposed rule making indicates that Medicaid will be potentially addressed in a later effort. This is particularly important in the context of provider obligations to report and return overpayments under Medicaid, and we believe that CMS should be very clear i this proposed rule that when it defines the terms of the statute, for example "identify" or "reconciliation" that those definitions for Medicaid purposes are being reserved to the states to allow those ambiguous terms to be defined in the context of their own programs at some future date. Without such a clear indication that those definitions are being left to the states for Medicaid purposes providers would be left in an even more confused position than before this rulemaking, especially with regard to the scope and reach of the term "reconciliation," given state reconciliation processes may differ. **Thus, we request that CMS clarify that states have latitude to define reconciliation and other key terms within the context of their state Medicaid programs.**

"Identification" Standard Disregards the Real World Difficulties and Challenges in Accurately Quantifying the Amount of an Overpayment

CHA urges CMS to revise its proposed definition of "<u>identified</u>" for purposes of triggering the 60-day window to report and repay to reflect with a reasonable amount of certainty that an overpayment exists. Refining the definition of "identified" is required to remain consistent with the statutory intent to safeguard Medicare and Medicaid trust funds, while also giving providers the flexibility necessary to investigate complex situations that may not be resolvable within 60 days. **More specifically, CHA recommends that the definition of "identified" be redrafted to allow for the ability to identify an overpayment when, after receipt of reliable evidence (as defined at 42 C.F.R. § 405.902), and through the exercise of reasonable diligence, a person can verify that an overpayment has occurred and with a reasonable degree of certainty quantify the overpayment.**

As you know, hospitals are undergoing numerous RAC and MAC audits, requiring the review of medical records on any number of issues every 30 to 45 days for review. At the time the auditing agency "identifies" an area of potential overpayment to the provider, one could argue that as written this proposed rule would deem the simple identification of the overpayment by the agency as knowing or knowingly be aware of the potential of an overpayment, triggering the duty to investigate.

CHA urges CMS to delete the use in the proposed rule of the 'knowing' or 'knowingly' standard of the False Claims Act to fix the point in time that a provider or supplier "identified" an overpayment. CMS acknowledges in the preamble that the statutory text does not use the phrase "knowing" or "knowingly" other than in the definition. Despite this, and without elaboration, CMS concludes that "Congress' use of the term 'knowing' in the ACA was intended to determine the point an overpayment is identified." This determination is not supported by the language in the statute or the ACA's legislative history. In fact, the legislative history supports the conclusion that both chambers rejected including a knowledge standard to identify an overpayment.

With that said, taking the provisions in context, 42 U.S.C. § 1320a-7k(d)(4) expressly provides that the terms "knowing" and "knowingly," "in this subsection," have the meaning defined for those terms in the federal FCA. Therefore, to the extent those terms are not used "in this subsection" (*i.e.*, in 42 U.S.C. § 1320a-7k(d) reporting and repayment obligations), it is inconsistent with the plain language of the statute to imply those words where Congress did not see fit to insert them. Congress uses the terms "knowing" and "knowingly" in multiple statutes, including overpayments that are subject to the civil monetary penalty ("CMP") statute. Congress uses the federal FCA's knowledge standard — including in the context of failing to report and return overpayments — **but chose not to do so to define the point at which an overpayment is "identified."** (42 U.S.C. § 1320a-7k(d).)

Any doubt of Congress' intent can be fully resolved as a consequence of its decision to eliminate the federal FCA knowledge standard to modify "overpayment" in the final version of Section 6402(a) as compared to the version that passed the House of Representatives. In addition to being inconsistent with the plain text of the statute, applying the FCA's knowledge standard to "identification" would lead to extreme and undesirable results, particularly in complex overpayment cases.

In the proposed rule, CMS has gone beyond what Congress had intended. CHA urges CMS to redraft the definition of "identified" to eliminate any ambiguity that knowing of a potential billing error starts the 60-day timeframe to report and repay. The resulting compliance requirements — to report and repay — within 60 days should be based on more than an indication, and should provide for time to investigate and determine with reasonable certainty that it must report and repay the overpayment.

Calculating the Amount of an Overpayment Is Complex and Requires Rigorous Review for Accuracy

As previously discussed, the process required to report and repay is triggered when an overpayment is "identified." The inability to report and repay overpayments within 60 days exposes providers to liability under the federal FCA, and also implicates the CMP statute, with penalties of up to $10,000 for each item or service claimed, treble damages, and potential exclusion from federal health care programs. Yet the proposed rule provides a definition of "identified" to trigger a reporting deadline that completely ignores the complexity of billing and reimbursement rules, and circumstances and scenarios in which a provider may know of an overpayment, and circumstances making it impossible to quantify within 60 days, even with use of reasonable or extraordinary diligence.

Given the complexities of the billing and payment rules for both Medicare and Medicaid, CHA urges CMS to give providers the necessary flexibility to analyze the breadth and scope of the billing error and to investigate, articulate, and quantify overpayments with reasonable certainty. This is essential, particularly given the harsh consequences for billing errors not repaid within 60 days.

As CMS is well aware, claims investigations will differ depending on the type and size of the provider and or the nature of the billing irregularity. In certain situations, billing investigations could require the analysis of hundreds, or possibly thousands, of claims, often with some manual component to review and evaluate. Quantifying the overpayment within 60 days could be impossible if it stems from underlying decisions about medical necessity that can only be determined by review of the medical records. Hospitals in California report that our Medicare Recovery Audit Contractor, Health Data Insights, is often challenged in completing its medical record review within its required 60 days.

Even assuming the provider has resolved to its satisfaction questions regarding the applicable underlying payment rules (which often are unclear or subject to differing interpretations), simply completing the analysis of the claims or medical records at issue may take longer than 60 days. This issue is further

exacerbated when the provider lacks the necessary financial resources or qualified personnel to complete the audit.

For example, several California hospitals have recently been subject to an intensive Office of Inspector General (OIG) audit. Prior to the onsite review of medical records, hospitals are asked to review anywhere from 50 to 200 records and make a determination as to whether or not an overpayment may be present. In some instances, CHA has learned that through internal review, prior to onsite reviews by OIG, hospitals had identified overpayments and wished to make the repayment within 60 days. However, each hospital was advised from doing so by OIG auditors until such time as the audit was complete and agreement reached on the appropriate calculation of the total overpayment. **To date, the audits have taken well over 100 days to complete and several still remain unresolved.** Hospitals remain concerned that they are currently at risk. The timing of the audits far exceeds the 60-day timeframe, yet there is no mention of such audits and how they would be addressed under this proposed rule.

Given the consequences for a late notice and payment, providers must be able to: (1) determine there is reliable evidence that an overpayment occurred; (2) have sufficient time to analyze the underlying payment rules and systems to isolate the billing errors; and (3) through reasonable diligence, be able to fairly and accurately quantify the amount of the overpayment with a reasonable degree of certainty. **For these reasons, defining the point in time that an overpayment is "identified" — and thus when the 60-day clock begins to tick — is singularly the most critical component of the 60-day rule, and one which requires a more flexible and thoughtful approach than the proposed rule articulates. The irony in the proposed rule's definition of "identified" is that the more complex the overpayment issue, the less likely any provider will be capable of complying with the 60-day rule, and the more likely the provider will be subject to CMP liability and potential federal FCA liability.**

As previously mentioned, CHA recommends that CMS narrow "identified" by use of "reliable evidence." The standard in the proposed rule requiring reasonable inquiry and diligence with "all deliberate speed" is ambiguous, and places significant pressure on a provider's ability to conduct internal audits and rapid investigations.

Another concern regarding the use in the proposed rule of the federal FCA's knowledge standard, while not equivalent to a "knew or should have known" standard, is that it creates substantial uncertainty for providers regarding the possibility that CMS or other regulators — or potential *qui tam* relators — may come in behind a provider and second-guess whether a provider exercised "reasonable diligence" and made a "reasonable inquiry" "with all deliberate speed" in determining when an overpayment should have been identified. In this regard, CMS's discussion that providers must "make a reasonable inquiry" "with all deliberate speed" appears to set a higher standard for a provider's obligation to investigate potential overpayments than does the "deliberate ignorance or reckless disregard" standard set forth in proposed 42 C.F.R. § 401.305(a)(2). CHA believes that the appropriate standard would be a provider's receipt of "reliable evidence" (as such phrase is defined at 42 C.F.R. § 405.902) that an overpayment may have occurred. Such a standard would provide some degree of comfort that providers would not be under an obligation to investigate every "whiff" of an overpayment.

The 60-day timeframe, triggered by "identified," requires further flexibility and guidance to address whether and to what extent CMS would accept an investigation that extends beyond 60 days.

Eliminate the 10-Year Look-Back Period

CHA urges CMS to eliminate the proposed 10-year look-back period and retain the existing four-year reopening period under current Medicare regulations as the appropriate time period for

addressing overpayments for billing errors. Any enhanced look-back period should be reserved to circumstances evidencing fraud or similar fault, consistent with the existing reopening rules.

The proposed rule would create a 10-year look-back period. It appears that this is based on the Department of Justice's view of the statute of limitation applicable to the FCA for intent-based overpayments. **This link to the look-back period for prosecuting fraud is completely inappropriate for overpayments for self-disclosed billing errors under the 60-day rule.** The 10-year look-back period in the FCA is an outer limit that, by its nature, addresses intentional fraud for knowingly concealing, decreasing or avoiding an obligation. Under the proposed rule, the inability to return and repay an overpayment past the 60-day deadline would trigger an obligation (and exposure) to FCA liability. Yet as discussed above, it would be very time consuming, if not impossible, to go back ten years and evaluate all claims that may have suffered the same billing error.

Using a 10-year look-back period for billing audits identifying errors is an unprecedented and significantly burdensome shift in policy. It also creates an inequitable result for CMS to impose a 10-year look-back period for identifying and repaying ***overpayments*** without the same offset for identifying and repaying ***underpayments***. The existing Medicare claims reopening rules sufficiently address overpayment self-disclosures under the 60-day rule. For overpayments where there is no evidence of fraud or similar fault, a provider is subject to a four-year look-back period because self-disclosure of an overpayment constitutes new and material evidence and good cause to do so. By contrast, however, an overpayment with evidence of fraud stops that existing four-year period from running. Thus, there is no justification for the expanded look-back, nor is there authority or intent for rewriting and expanding the statute.

The proposed rule does not consider the administrative burden on claims investigations that would result with such an extensive time period. There is no "magic-button," software solution, statistical model or other mechanism that can identify and accurately calculate the extent of an overpayment going back ten years. Billing systems change, automated determinations change, and regulations and billing requirements change.

Application of the Final Rule

The ACA does not provide for retroactive application, nor does CMS in its rulemaking authority provided by Congress. This would raise significant legal issues for enforcement, and conflicts with existing case law and Medicare's "without-fault" rules (42 U.S.C. §1395gg(c) and 42 C.F.R. §405.350(c)). This level of retroactivity would make it nearly impossible to rely on claims adjudication and payments required for financial stability and projections. Such change could only apply to claims or cost reports filed after the date of the final rule.

CHA urges CMS to issue a final rule that is consistent with existing Medicare reopening rules, to reject the proposed 10-year look-back period to prosecute fraudulent activities under the False Claims Act, and to apply the final rule only on a prospective basis and not retrospectively.

"Applicable Reconciliation" Should Encompass Processes Beyond Cost Report Reconciliation

Under ACA section 6402(a), an overpayment does not occur until funds are retained by a person, after applicable "reconciliation." Because the report and return requirement are not triggered until after "applicable reconciliation," it is particularly important for CMS to carefully define that concept. The proposed rule defines "applicable reconciliation" narrowly to include only cost report reconciliation

occurring with the provider's submission of a cost report (with two limited exceptions for subsequently published SSI ratios and outlier reconciliation), where such reconciliation would affect the overpayment. This proposed definition would not apply to claims or the claims process, and does not apply to the audit process for cost reports except as noted above. Such a limited definition is inconsistent with statute and will lead to an expansion of significant burdens on providers and MACs beyond what Congress contemplated, and create record keeping problems on repayment.

There is no reasonable basis for the proposed rule's definition of "applicable reconciliation" to exclude the claims correction process and to limit the cost report reconciliation process to only two items in the audit process. In excluding the claims correction process, CMS appears to be relying too heavily on an example in the FERA legislative history without regard to the context of that example. *See* S. Rep. No. 111-10 at 15 (Mar. 23, 2009) ("The Committee does not intend this language to create liability for a simple retention of an overpayment that is permitted by a statutory or regulatory process for reconciliation provided that the receipt of the overpayment is not based on any willful act of a recipient to increase the payments from the Government when the recipient is not entitled to such Government money or property.... Accordingly, any knowing and improper retention of an overpayment beyond or following the final submission of payment as required by statute or regulation – including relevant statutory or regulatory periods designated to reconcile cost reports, but excluding administrative and judicial appeals – would be actionable under this provision."). Simply stated, even in FERA, Congress was concerned that a report and return obligation would frustrate and confuse already existing statutory and regulatory processes to fix errors. There is no statutory directive under Section 6402(a) to construe "applicable reconciliation" so narrowly, and such a restrictive approach would be inconsistent with comments CMS has made in its previous two rulemakings relating to Medicare overpayments, which indicate that applicable post-payment adjustments should be allowed to run their course before an "overpayment" exists:

> Overpayments generally result when payment is made by Medicare for noncovered items or services, when payment is made that exceeds the amount allowed by Medicare for an item or service, or when payment is made for items or services that should have been paid by another insurer (Medicare secondary payer obligations). Once a determination and any necessary adjustments in the amount of the overpayment have been made, the remaining amount is a debt owed to the United States Government. [63 Fed. Reg. 14506, 14506 (Mar. 25, 1998) (emphasis added)]
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> For overpayments identified by other entities, other than managed care organizations, the other entities must notify us in writing of the overpayment within 60 days of identifying or learning of the excess payment, so that we can recover the identified overpayment appropriately. Submission of corrected bills in conformance with our policy, within 60 days, fulfills these requirements for providers, suppliers, and individuals.[67 Fed. Reg. 3662, 3663 (Jan. 25, 2002) (emphasis added).]

These prior comments by CMS articulate a sensible position that would support a more expansive definition of "applicable reconciliation" — one that would include a broad range of statutory and regulatory post-payment review processes. For example, many providers have relied on Medicare's existing claims correction process to adjust overpayments without resorting to the 60-day rule's report and refund provisions, and this approach has enabled quick and relatively inexpensive resolution of such

overpayments. Given the Proposed Rule's ostensible goal of relying on existing processes to implement the 60-day rule (*e.g.*, the voluntary refund and ERS request processes), it is unconscionable for CMS to propose to preclude providers from utilizing the existing Medicare claims correction processes to resolve overpayments where the claims are within the one-year resubmission window. A broader definition of "applicable reconciliation" that permits use of existing statutory and regulatory post-payment adjustment processes, as well as pre-enforcement voluntary self-disclosure processes like the SRDP and OIG SDP, would preserve Section 6402(a)'s program integrity goals while recognizing that these existing processes should be permitted to run their course before a provider knows that it has received funds "to which the person … is not entitled" and which thus constitute an "overpayment."

Finally, the proposed rule is overly restrictive even with regard to this more limited definition. There is no legal or policy justification for asserting "the general rule that the applicable reconciliation occurs with the provider's submission of a cost report" and then limiting exceptions exclusively to SSI ratio publication and outlier reconciliation. First, section 6402(a), by its very terms, recognizes the deadline for submission of a cost report as tolling the 60-day deadline. Thus, cost report submission is separate from the other statutory provision that forecloses an overpayment that triggers report and return based on a reconciliation process. Reconciliation, in this context, must mean a process that occurs subsequent to the submission of the cost report. Also, practically, there are many categories, in addition to the two that CMS identifies in the proposed rule, which are not entirely known to the provider at the time of initially filing the as-filed cost report, which are reconciled through the audit process, and finalized with the issuance of a Notice of Program Reimbursement ("NPR"). For example, with respect to home office cost statements ("HOCS"), providers usually file an estimate of home office costs on the hospital cost report, which is subsequently reconciled to the HOCS when the MAC audits the HOCS; the proposed rule should (but does not) extend "applicable reconciliation" to include this process. Other cost report categories subject to similar post-submission reconciliation include, but are not limited to: any interim payments such as Medicare bad debt or graduate medical education ("GME"); sole community / Medicare-dependent hospital payments; end-stage renal disease ("ESRD") payments; organ payments; nursing and allied health payments; and HITECH Act EHR incentive payments. These and other issues can arise subsequent to a provider's submission of an initial or amended cost report that may affect the amount of a provider's Medicare or Medicaid payments, but which are not included in the two exceptions CMS has provided in the proposed rule.

CHA urges CMS to broaden the definition of "applicable reconciliation" to include: (1) all forms of reconciliation provided by law and (2) with respect to Medicaid payments, such statutory or regulatory reconciliation processes as each state may choose to define.

At a minimum, CHA requests CMS expand the general rule to define "applicable reconciliation" as occurring upon final reconciliation of a provider's cost report, so long as — with respect to any issue subject to cost report audits that could affect a provider's Medicare payment — the provider promptly discloses the issue to the MAC for purposes of preparing a final cost report settlement.

Reporting and Repayment Requirements Overlap and Conflict

CHA urges CMS to treat self-disclosures under the Medicare Self-Referral Disclosure Protocol (SRDP) and OIG Self-Disclosure Protocol (OIG SDP) the same for purposes of tolling the 60-day reporting and repayment deadline, and suspend the obligation both to return and to report an overpayment when the provider timely self-discloses an overpayment.

The proposed rule uses the current voluntary refund process as the mechanism for receiving overpayments under the "self-reported overpayment refund process." For reasons that are unclear and not articulated by CMS, the proposed rule distinguishes between the effect of a self-disclosure under the Medicare SRDP, on the one hand, and a self-disclosure under the OIG SDP, on the other hand, with respect to suspending certain requirements under the 60-day rule. A self-disclosure under the SRDP would suspend a provider's obligation to return, but not to report, an overpayment; whereas a self-disclosure under the OIG SDP would suspend both a provider's obligation to return and to report an overpayment. There is no legal or policy basis for distinguishing between these two processes, and the proposed rule as written would subject providers to duplicative and unnecessary reporting requirements in cases where a provider self-discloses an overpayment to CMS under the SRDP. CHA objects to these duplicative and unnecessary reporting requirements that only add costs to the health care system.

Once CMS adequately addresses the issues of scope, identification and calculation of the overpayments, CHA urges CMS to clearly articulate a uniform overpayment reporting form with clear definitions and guidance and make it publicly available on all Medicare and Medicaid contractor websites.

CHA appreciate CMS' intent to utilize "the existing voluntary refund process" for reporting and returning overpayments. Consideration of existing processes may mitigate some of the reporting burden on providers. However, absent a uniform reporting form and additional guidance, the existing voluntary refund forms currently used by various contractors do not incorporate all of the mandatory elements of the report articulated in the proposed rule and must be revised. For example, the overpayment refund form used in Region IX does not include four of the fields required in the proposed rule: (a) the tax identification number; (b) how the error was discovered; (c) a description of the corrective action plan to ensure errors do not recur; or (d) if the calculation was by means of a statistically valid sample and method. Again, a universal overpayment reporting form would go a long way in streamlining and easing providers' administration and implementation of existing overpayment rules and methods.

Impact Analysis of the Proposed Rule Is Woefully Inadequate

CHA believes that CMS dramatically understates the compliance burden resulting from the provisions articulated in the proposed rule. The combination of the expansive definition of "identified," the narrow definition of "applicable reconciliation," the relatively brief 60-day reporting and repayment timeframe, and the significant potential federal FCA and CMP liability, make it much more likely that hospitals will experience a tremendous administrative burden resulting from the de facto duty to investigate. As it stands, any inkling of a billing error triggers "knowledge." Knowledge without more information triggers a billing error being "identified, which starts the 60-day clock to investigate, going back 10 years, to determine if it was an isolated error, if it was based on a medical necessity error or other scenario that requires more thorough review, a systemic error in the billing system, or any number of other scenarios, including applicable rules at the time the bill was generated. These requirements amount to what is not only a duty to investigate, but in some instances may be an impossibility, if, for example, billing software changed or some other scenario beyond the provider's control. The only explanation for the input analysis is that CMS only took into account a small fraction of the totality of the requirements to report and repay identified billing errors within 60 days.

CHA urges CMS to revisit its estimate of the compliance burden and in doing so, make the CHA recommended changes as articulated above. The revised regulatory impact analysis must account for the time required to report and repay known overpayments. In addition, the analysis at a minimum should appropriately estimate time and resources needed to account for the ability to investigate and gather reliable evidence to calculate with reasoned certainty the extent of a billing

error. As drafted, the proposed rule appears to account for time it may take to generate the necessary reporting form notifying CMS of the error, but it disregards completely the time it takes to accurately and reliably obtain the information necessary to report claims errors resulting in overpayments.

In addition, CMS's estimates of the time and expense involved in reporting and repaying such overpayments appear to be unrealistically low, given the complexity providers and their counsel frequently encounter investigating and analyzing whether there has been an overpayment, and then calculating the amount of the overpayment. The hourly wage estimate does not appear to account for time or expense involved in engaging compliance officers and counsel (external and in-house), whom providers frequently rely on when analyzing and resolving overpayment disclosures under the 60-day rule.

Hospitals report that these audits are increasing in costs as they must be conducted by external consultants due to the volume and regularity of the multiple audits. The costs continue to increase, diverting precious resources from direct patient care.

Given the importance of determining whether an overpayment is "identified," the time and expense associated with conducting a "reasonable inquiry" when a provider receives reliable evidence that an overpayment may have occurred can be significant. This is particularly true when a potential overpayment issue might require engagement of an outside consultant to analyze multiple claims across multiple facilities, or significant investigation is necessary to develop facts surrounding a potential overpayment (such as an anonymous compliance hotline complaint). Moreover, even to the extent a provider has identified and quantified a potential overpayment issue, the mechanics of reporting the issue to the appropriate payor and detailing how the error was discovered, the reason for the overpayment, the provider's corrective action plan, and the sampling methodology used to determine the overpayment (if applicable) often requires drafting a narrative attachment to the overpayment refund form. Providers frequently engage counsel to draft, or at least review, such narrative attachments, yet the proposed rule does not appear to reflect the time associated with these activities.

Finally, as clearly stated, the proposed rule presents several significant operational, technical and legal issues that must be addressed. CHA and our member hospitals are committed to ensuring payment accuracy. With that said, we feel strongly that this proposed rule goes far beyond the legislative intent and creates unnecessary burdens for hospitals. Under the proposed regulations, hospitals would find themselves, once again, in a position of guilty until proven innocent and would be required to expend extraordinary financial and personal resources that would be diverted from direct patient care.

CHA appreciates the opportunity to provide comments on the proposed rule. We urge CMS to give careful consideration to our comments and recommendations and make the necessary changes to ensure that hospitals have an appropriate pathway to ensure that overpayments can be repaid. If you have questions, please do not hesitate to contact me at (202)488-4688, akeefe@calhospital.org or my colleague Jana DuBois, vice president general counsel, at (916)552-7636, jdubois@calhospital.org.

Sincerely

/s/
Alyssa Keefe
Vice President, Federal Regulatory Affairs