



April 16, 2012

Ms. Marilyn Tavenner
Acting Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

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

Dear Acting Administrator Tavenner:

AARP appreciates the opportunity to comment on the proposed rule published in the *Federal Register* on February 16, 2012 implementing new section 1128J(d) of the Social Security Act, as added by section 6402(a) of the Affordable Care Act (ACA) to require Medicare providers of services and suppliers to report and return overpayments made to them under the Medicare program. AARP is a nonprofit, nonpartisan membership organization that helps people age 50+ have independence, choice and control in ways that are beneficial and affordable to them and society as a whole. AARP has a keen interest in the long-term viability of the Medicare program and to that end in identifying and promoting policies to combat waste, fraud and abuse against the program. AARP seeks to protect Medicare beneficiary access to physicians and other health care providers and suppliers who furnish items and services covered under the program as well as to prevent inappropriate charges, through cost-sharing, on beneficiaries for the errors or fraudulent activities of others.

We commend the Centers for Medicare & Medicaid Services (CMS) for its proposed rule to implement section 1128J(d) of the Social Security Act which would require institutional providers of services and suppliers who receive overpayments from Medicare contractors for fee-for-service medical care furnished to Medicare beneficiaries to report and return those overpayments within 60 days of identifying the overpayment or in conjunction with the filing of a provider cost report. AARP strongly encourages CMS to move as soon as possible to promulgate regulations for the implementation of section 1128J(d) with respect to Medicare Advantage Organizations, Sponsors of Medicare Part D Prescription Drug Plans, and Medicaid Managed Care Organizations. As noted in the proposed rule, CMS believes these organizations are subject to statutory requirements to report and return overpayments without implementing regulations. While this may be the case, the interaction among various pre-ACA fraud and abuse laws, and related current regulatory requirements for

reporting overpayments, and the new requirements of section 1128J(d) requires coordination and potentially, under certain circumstances, special rules with respect to repayment of overpayments. The prompt provision of rules and guidance for these organizations to comply with the provisions of the law will obviate confusion and improve compliance rates.

AARP appreciates the clarification in the proposed rule that the statutory definition of person, for purposes of reporting and returning overpayments, does not include beneficiaries. While that interpretation is a logical reading of the statute, clarification on the matter eliminates doubt and reduces concerns on part of beneficiaries and their advocates, and we encourage CMS to finalize this proposed definition.

Under the proposed rule, CMS would develop a single, unified form, in lieu of separate forms maintained by individual Medicare contractors. AARP commends CMS for this initiative and encourages CMS to make the form available to Medicare contractors in the very near future. We believe that it will lead to greater consistency for providers of services and suppliers to report and return overpayments and minimize, if not eliminate entirely, confusion among contractors in their interpretation and application of statutory and regulatory requirements.

With respect to potential impact on access to Medicare items and services by beneficiaries, CMS should closely consider the impact of the burden of the proposed rule for errors made by small or sole providers of services or suppliers, especially individual or small physician group practices, in areas where beneficiary access to services may be or is currently limited. The documentation and process requirements that apply to a provider or supplier under the Extended Repayment Schedule (ERS) for financial hardship combined with the timing for return of overpayments under section 1128J(d) may operate to deny these providers or suppliers sufficient time to qualify for the ERS repayment schedule. CMS should consider methods to streamline the ERS financial hardship process in the case of small or sole providers of services and physicians in such areas to ensure continued beneficiary access to Medicare covered services or alternatively consider other means to promptly consider these financial hardship exception requests, perhaps through an attestation or certification methodology.

CMS should also consider the impact of its proposed look back period of 10 years on physicians and other small suppliers, and on smaller institutional providers of services. At the present time, many medical records maintained by physicians and providers are paper records; the transition to electronic health records is progressing slowly. Until such time as electronic health records are the norm, the burden on providers and suppliers to maintain 10 years of complete paper records, and further to be able to promptly search through them for a potential error before the end of the swift 60-day deadline, is a significant burden and may encourage physicians to opt out of the Medicare program at a time when the rate of new beneficiaries entering the program is

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increasing dramatically. Should CMS retain the 10-year look back period in the final rule, the agency could consider prospective application of the rule.

Additionally, we agree that CMS should seek to minimize any duplicative reporting requirements with respect to overpayments, such as would appear to apply, for example, under both section 1128J(d) and the Medicare Self-Referral Disclosure Protocol (SDRP). The proposed rule would treat an overpayment notification made to the Office of the Inspector General (OIG) of the Department of Health and Human Services through the OIG Self-Disclosure Protocol as a report for purposes of section 1128J(d). It is unclear why similar treatment would not be appropriate in the case of providers or suppliers self-disclosing actual or potential violations of section 1877 to CMS through the SDRP. CMS should also provide clear and uniform guidance to its contractors underscoring that not every overpayment report is indicia of fraud or abuse against the program for referral to the OIG or CMS. Coordination is important among contractors and the agencies entrusted with enforcing the fraud and abuse laws, but that should not result in automatic referral of each overpayment report and accompanying payment to the OIG or CMS.

AARP appreciates this opportunity to comment on this rule. If you have any questions, please feel free to contact Leah Cohen Hirsch of our Government Affairs staff at 202-434-3770.

Sincerely,

A handwritten signature in black ink, appearing to read "David Certner". The signature is fluid and cursive, with a long horizontal stroke extending to the right.

David Certner
Legislative Counsel and Legislative Policy Director
Government Affairs