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# HHS Publishes Proposed Rule Implementing 60-Day Overpayment Refund Statute for Medicare Part C and D Plans

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Under the so-called "60-day rule" statute, codified at § 1128J(d) of the Social Security Act, Medicare and Medicaid providers, suppliers, and plans risk liability under the Federal False Claims Act if they fail to report and return certain identified overpayments within 60 days or by the date any corresponding cost report is due. Although this onerous statutory requirement was enacted nearly four years ago as part of the Affordable Care Act, no final rules implementing the 60-day rule have yet been adopted. On February 16, 2012, CMS published its notice of proposed rulemaking regarding Medicare provider and supplier obligations to report and return overpayments arising under Medicare Parts A and B. This nearly two-year old proposed rule has not yet given rise to a final rule and, by its own terms, did not address overpayments arising under Medicare Parts C and D or Medicaid. Thus, the 2012 proposed rule left open questions concerning the scope of the 60-day rule obligations of Medicare Part C and D plans, and the potential for downstream providers or suppliers to incur repayment obligations as a result of payment made by Part C and D plans.

On January 10, 2014, HHS published a proposed rule for the Medicare Advantage and drug benefit programs that would implement the 60-day rule for the Medicare Part C and D programs.[1] The proposed rule focuses exclusively on Medicare Advantage Organizations (MAOs) and Prescription Drug Plan (PDP) sponsors. It would impose no 60-day rule obligations on provider payments from MAOs or PDP sponsors, suggesting that the 60-day rule only applies to providers and suppliers when they receive overpayments under Medicare Parts A and B or a Medicaid program.

## Overview and Scope of 60-Day Rule

The 60-day rule applies where a provider of services, supplier, Medicaid managed care organization, MAO, or a PDP sponsor receives or retains funds to which, after appropriate reconciliation, it is not entitled under the Medicare or Medicaid programs. Once an overpayment is "identified," the provider or plan must report and return the overpayment within 60 days or by the date any corresponding cost report is due, whichever is later. Both of the proposed rules for the Medicare program would provide that an overpayment is "identified" once the provider or plan has actual knowledge of the overpayment or acts in reckless disregard of or deliberate indifference to the existence of the overpayment.

The statute does not establish a look-back period for the 60-day rule report and return obligation, and a couple of court cases suggest that there are limits to the statute's retroactive effect. The 2012 proposed rule for providers and suppliers included a 10-year look-back period for claims but suggests that cost report issues are subject to administrative finality, while the proposed rule for MAOs and PDP sponsors includes a 6-year look-back period. It is unclear if this difference reflects the government's attempt to account for differences between provider and plan overpayments or, perhaps, is a result of comments criticizing the 10-year lookback in the 2012 proposed rule.

## Proposed Rule for MAOs and PDP Sponsors

The new proposed rule would define "funds" to somewhat narrow the definition of "overpayment" under Medicare Parts C and D. Under the proposed rule, "funds" would be restricted to payments made by the government to MAOs or PDP sponsors that are based on data that the plans submitted to CMS for payment purposes where the MAO or PDP is responsible for the accuracy, completeness, and truthfulness of the data under existing rules. For MAOs, the specified data includes enrollment data and risk adjustment data. For PDP sponsors, it includes drug claims data under section 423.329(b)(3), cost data applicable to risk sharing arrangements (§ 423.336(c)(1)), cost data applicable to retroactive adjustments and reconciliations (§ 423.343), and data provided for purposes of supporting allowable costs (§ 423.308), which includes data submitted regarding direct or indirect remuneration.

The processes that MAOs and PDP sponsors will use to report the amount and reason for an overpayment and to return overpayments have not yet been established by CMS. Interestingly, the proposed rule notes that overpayments will be deemed "returned" when the MAO or PDP sponsor submits corrected data. CMS will then recover the "returned" overpayments through routine processing. In some cases, however, CMS may require the MAO or PDP sponsor to return the overpayment by making payment to CMS using an auditable estimate of the overpayment amount. This might occur, for example, if the MAO or PDP sponsor experiences a thoroughly documented catastrophic loss of stored data.

## Conclusion

We anticipate that CMS will finalize this proposed rule for MAO and PDP sponsor overpayments in 2014 and the agency may also issue this year the final rule on provider and supplier overpayments under Medicare Parts A and B. To date, rule-making has not been initiated to implement the 60-day rule as it relates to state Medicaid programs and we hope such rule-making will not be initiated until CMS moves further to either finalize or re-propose the Parts A and B rule-making. While the proposed rule for MAO and PDP sponsor overpayments does not directly address provider obligations, it may suggest that CMS has responded to criticism of the proposed 10-year look-back for providers and suppliers and is moving toward a shorter look-back period for all persons regulated by the 60-day rule. In addition, we view the proposed rule's focus on MAO and PDP sponsor obligations and silence with regard to provider and supplier

obligations arising from plan payments as a promising sign that such downstream payments are not subject to the 60-day rule.

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[1] Contract Year 2014 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs, 79 Fed. Reg. 1918, 1995 – 1998 (proposed Jan. 10, 2014), at http://federalregister.gov/a/2013-31497.