Via Electronic Transmission

November 21, 2006

Ms. Leslie Norwalk, J.D.
Acting Administrator
Centers for Medicare and Medicaid Services
Room 445-G
Hubert Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: **Notice of Proposed Rulemaking on Limitation on Recoupment of Medicare Overpayments [CMS – 6025 p]**

Dear Ms. Norwalk:

The American Association for Homecare (AAHomecare) submits the following comments in response to the Centers for Medicare and Medicaid Services' (CMS') request for comments on the above captioned proposed rule. AAHomecare is the only national association representing every line of service within the homecare community. AAHomecare members include providers of oxygen equipment and therapy, providers and manufacturers of durable medical equipment (DME), prosthetics, orthotics, and supplies (collectively "DMEPOS") including rehab and assistive technologies, home health agencies, and pharmacies that provide home infusion and inhalation drug therapies to patients in their homes. Our membership reflects a cross-section of the homecare community, including national, regional, and local providers and suppliers. With approximately 800 member companies at 3,000 locations nationwide, AAHomecare and its members are committed to advancing the value of quality health care services at home.

As you are aware, §935 of the Medicare Modernization Act (MMA) amended §1893 of the Social Security Act (the "Act") by adding a new paragraph (f) that limits the Secretary's authority to recoup Medicare overpayments. Specifically, the Secretary may not take any action, or permit a contractor to take any action, to recoup an overpayment from a provider[1] that seeks a reconsideration from a qualified independent contractor "QIC" until the date a decision on the reconsideration has been rendered. Before Congress passed §935, a provider was subject to recoupment within 30 days of an overpayment notice regardless of whether the provider

[1] We are aware that the individuals and entities that furnish DMEPOS items are included within the definition of "suppliers" under the Act and CMS regulations. These comments use the term "provider/s" interchangeably with "suppliers."

requested an administrative review of the overpayment determination. Providers were subject to immediate recoupment despite the existence of a legitimate dispute about the factual or legal basis for the overpayment and notwithstanding that a substantial majority of providers that appealed an overpayment decision succeeded in having it overturned. In passing §935, Congress rectified an imbalance in CMS' process which permitted it to recoup substantial funds from a provider even though the basis for the recoupment was disputed.

AAHomecare strongly supported the inclusion of §935 in the MMA. We similarly support the need to implement this legislation through rulemaking. Nonetheless, we are concerned that the provisions of the proposed rule undermine Congress' intent as expressed in §935 and when considered in light of the Medicare appeals process reforms Congress passed under the Benefit Improvement and Protection Act of 2000 (BIPA). Although BIPA established the timeframes for initiating timely appeals from determinations and redeterminations, the proposed rule would compromise these rights for providers that want to avoid recoupment. We question CMS' authority to limit appeal rights in this fashion. As we explain more fully below, CMS should implement the recoupment limitation in a manner that is consistent with Congress' intent under §935 and the BIPA Medicare appeals reforms.

I. Comments on the Provisions of the Proposed Regulations

A. Initiating Recoupment After Notice of an Overpayment

The proposed regulations define the overpayments to which the recoupment limitation applies, explain how the limitation works as part of the appeals process, and describe the change in CMS' obligation to pay interest to a provider whose appeal is successful at levels above the QIC.[2] Under CMS' proposal, the recoupment limitation applies from the time a provider timely appeals to the first two levels of appeal until the QIC renders its decision.[3] Recoupment of an overpayment, once initiated, will be stopped at the redetermination and the reconsideration levels of appeal when a "timely and valid" appeal request applicable to that level is received. The provider need not take any affirmative action to invoke the limitation on recoupment beyond the act of appealing.

We support CMS' decision to exercise its discretion to interpret §935 broadly by applying the recoupment limitation to both the redetermination and reconsideration levels of appeal. Although the MMA explicitly references only the QIC level of appeal, CMS reasons that, because providers must request a redetermination from the Medicare Administrative Carrier (MAC) before requesting a reconsideration, Congress' intent under §935 would not be given effect unless the recoupment limitation applied to requests for a redetermination as well. We agree with this reasoning in light of Congress' mandate to the Secretary under §935.

For similar reasons, we believe that CMS' proposal to commence recoupment immediately after the overpayment is determined and the requirements for rebuttal[4] are satisfied is overly narrow.

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[2] These proposed changes are to be codified in 42 CFR §§ 405.370, 405.373, 405.378, and 405.379.

[3] Proposed to be codified as 42 CFR §§ 405.373(e), 405.379.

[4] As authorized under 42 CFR §§ 405.374, 405.375, proposed 42 CFR § 405.379(e)(1).

Under the proposed rule, recoupment will stop once the provider makes a valid and timely request for a redetermination of the overpayment decision, but CMS may recoup until then. Consequently, the proposed rule forces providers to request a redetermination as early as possible inasmuch as CMS can begin to recoup until the request is received. Similarly, following a redetermination that affirms the overpayment determination in whole or in part, the contractor can resume recoupment of any outstanding principal and interest within 30 days of the redetermination notice. Recoupment must stop once the provider makes a valid and timely request for reconsideration, but the proposed rule would permit recoupment to occur until then.[5]

CMS' proposal creates a significant conflict between a provider's right to timely appeal a determination or a redetermination and its right under §935 to limit recoupment. BIPA mandates that providers have 120 days from the date of a determination to *timely* request a redetermination and 180 days from the redetermination to request a *timely* reconsideration. The proposed rule undermines these requirements by forcing providers to choose either initiating an early appeal to foreclose recoupment, or taking full advantage of the timeframe for filing the appeal in order to increase their success on appeal. Moreover, providers who fail to introduce all relevant evidence before the QIC, will be precluded from presenting new evidence to an Administrative Law Judge (ALJ) absent good cause. As a practical matter, any provider that desires to preserve the opportunity for a successful appeal will recognize the need to forgo its right to limit recoupment in order to prepare the appeal.

We do not dispute that CMS' obligation is to protect public funds used to finance the Medicare program. We also understand that, once a payment to a provider has been determined to be in error, CMS must seek a refund. However, recoupment should not begin where there is a factual or legal dispute about the overpayment decision. Congress passed §935 precisely so that these disputes could be resolved, at least in part, before the provider is obligated to make a repayment. Clearly, CMS should have no interest in recouping funds that it has no legitimate right to recoup. By superimposing its own deadline on the timeframe established by Congress for requesting an appeal, CMS perpetuates the imbalance that §935 was intended to address. We recommend that CMS revise the proposed rule to preclude recoupment until the time for filing a timely request a redetermination or reconsideration has expired. Alternatively, CMS could require a provider to inform the contractor of its intent to initiate an appeal as part of the rebuttal procedure. Providers expressing their intent to appeal would not be subject to recoupment.

B. Initiating or Resuming Recoupment after QIC "Final Action" on Reconsideration Request

Under the statutory recoupment limitation, once a provider has sought a reconsideration by the QIC, CMS may not initiate or resume recouping the overpayment "until the date the decision on the reconsideration has been rendered." The proposed regulations interpret this phrase to be the date on which the QIC issues its "final action" with respect to a reconsideration.[6] The proposed

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[5] Proposed to be codified as 42 CFR § 405.379(e)(1)(ii).

[6] Proposed to be codified as 42 CFR § 405.379(f).

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Charles N. Kahn III
President

November 20, 2006

VIA HAND DELIVERY

Hon. Leslie Norwalk, Esq.
Administrator
Attention: CMS-6025-P
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G, Herbert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: ***CMS-6025-P; Medicare Program; Limitation on Recoupment of Provider and Supplier Overpayments; Proposed Rule; 71 Fed. Reg. 55404 (September 22, 2006)***

Dear Ms. Norwalk:

This letter presents the comments and recommendations of the Federation of American Hospitals ("FAH") to certain aspects of the proposed rule referenced above implementing Section 635 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (hereinafter "MMA 2003"), codified at Social Security Act section 1893(f) (hereinafter "SSA 1893(f)"). For the reasons set forth in detail below, we believe the proposed rule is inconsistent with the statutory mandate established through SSA 1983(f)(2) as a consequence of proposing to initiate recoupment beginning 30 days after a provider adverse initial appeal determination and within the time period to initiate a Qualified Independent Contractor (hereinafter "QIC") reconsideration.

The Federation of American Hospitals is the national representative of privately owned or managed community hospitals and health systems throughout the United States. Our members include teaching and non-teaching, short-stay and long-term care hospitals in urban and rural America, and provide a wide range of ambulatory, acute and post-acute services. The FAH greatly appreciates the opportunity to comment on CMS' proposed rule implementing the statutory protections afforded providers that are associated with the recoupment of overpayments.

Recoupment Within The Period Allowed for QIC Reconsideration

The Notice of Proposed Rulemaking indicates that in implementing the dictates of SSA 1893(f)(2) regarding recoupment, the Secretary had to balance competing objectives associated with the fiscal integrity of the Medicare program and providers to give effect to the Congressional limitation on the agency's right to recoup overpayments from providers. 71 Fed. Reg. at 55,407, col. 1. In balancing these asserted competing interests, the Secretary suggests that the agency could render ineffective the limitation imposed on recoupment in the new legislation by implementing recoupment before initial appeal determinations, but choose not to take such steps because they would be contrary to Congressional intent. *Id.* at col.2. Instead, in acknowledging that the statute may not provide the agency with any flexibility, the Secretary reads such flexibility into the statute to allow recoupment within the appeal window wherein a provider may seek reconsideration in a second level appeal. *Id.* at col.1. This occurs as a result of proposing to allow recoupment thirty days after a first level appeal, even though a provider has 180 days to lodge such a reconsideration request. Thus, as long as a provider requests reconsideration very early within the allotted time limit, under the proposed rule recoupment cannot occur until after a QIC reconsideration decision is rendered.

The proposed rule in this regard is entirely inconsistent with the new statute and its legislative history and will lead to results detrimental to the administration of the program. The statute that forms the basis for the proposed rule, SSA 1893(f)(2)(A), provides:

> In the case of a provider of services or supplier that is determined to have received an overpayment under this title and that seeks a reconsideration by a qualified independent contractor on such determination under section 1869(b)(1), *the Secretary may not take any action (or authorize any other person, including any Medicare contractor, as defined in subparagraph (C)) to recoup the overpayment until the date the decision on the reconsideration has been rendered.* [Emphasis added.]

The statute clearly provides that the earliest date upon which recoupment may commence is the date a reconsideration has been rendered. The statute contemplates that recoupment cannot take place before the reconsideration process, or, as the proposed rule recognizes, the new law would be meaningless. The Conference Report associated with MMA 2003 section 685 evidences Congressional intent in this regard: "The Secretary is prohibited from recouping any overpayments until a reconsideration-level appeal (or a redetermination by the fiscal intermediary or carrier if the QICs are not yet in place) was decided, if a reconsideration was requested." House Report 108-391 (Nov. 21, 2003) incorporating Conf. Rept. to accompany HR1. The only reasonable reading of the statute given this legislative history is that once a provider has commenced the appeal process, until such time as a QIC reconsideration can no longer be filed, recoupment cannot commence. If such a reconsideration request is filed within the applicable period, recoupment cannot commence until the reconsideration decision is rendered. Any other reading would lead to a violation of the statutory prohibition against recoupment even when a provider requests reconsideration.

The limitation on recoupment under the proposed rule, requiring the early filing of a reconsideration request within thirty days of an initial overpayment determination to avoid recoupment, may lead providers to indiscriminately appeal all initial level determinations. Such

a result would unnecessarily burden the reconsideration process and cannot be a consequence that Congress intended in protecting providers from recoupment. Instead, CMS should forestall recoupment until either the reconsideration period expires, in those instances where an appeal ultimately is not filed as required by statute. The applicable rate of interest for overpayments, currently in excess of ten percent, certainly should provide enough incentive for providers to avoid delays in the process through which an overpayment determination will become final, causing providers to be selective about the initial overpayment determinations they pursue.

The FAH appreciates the consideration of its comments. If you have any questions about our comments or need further information, please feel free to contact me or Steve Speil, Senior Vice President, of my staff at (202) 624-1529.

Respectfully,