

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850



Center for Medicaid, CHIP and Survey & Certification

SMDL# 10-014
ACA# 5

July 13, 2010

**Re: Extended Period for Collection of Provider
Overpayments**

Dear State Medicaid Director:

This letter is one of a series intended to provide guidance on the implementation of the Patient Protection and Affordable Care; (Pub. L. No. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010; (Pub. L. No. 111-152), together called the Affordable Care Act (ACA). Specifically, this letter provides initial guidance on Section 6506 of the Affordable Care Act, which is entitled, “*Overpayments.*” This section was effective March 23, 2010, the date of enactment, and provides an extension of the period for collection of overpayments. For overpayments identified prior to the effective date, the previous rules on discovery of overpayments will be in effect.

Under section 6506 of the Affordable Care Act, States now have up to one year from the date of discovery of an overpayment for Medicaid services to recover, or to attempt to recover, such overpayment before making an adjustment to refund the Federal share of the overpayment. Except in the case of overpayments resulting from fraud (discussed below), the adjustment to refund the Federal share must be made no later than the deadline for filing the quarterly expenditure report (Form CMS-64) for the quarter in which the one-year period ends, regardless of whether the State recovers the overpayment. Previously, States were allowed up to 60 days from the date of discovery of an overpayment to recover such overpayment before making the adjustment to the Federal share.

This change to Federal law does not affect the treatment of Federal credit for amounts actually collected prior to the expiration of the one-year time limit. Such amounts remain due on the CMS-64 form filed for the quarter in which the collection is actually made. As required under section 1903(d)(3) of the Social Security Act (the Act), OMB Circular A-87 *Cost Principles for State, Local and Indian Tribal Governments, Attachment A, Section C*, and Federal regulations at 45 CFR section 92.21(f), reported medical assistance expenditures must be net of all applicable credits. Applicable credits refer to those receipts or reduction of expenditure-type transactions that offset or reduce expense items allocable to Federal awards, including adjustments of overpayments. To the extent that adjustments of overpayments received by the State relate to allowable costs, they must be credited to the Federal award in the quarter in which the collection is made.

Section 6506(a)(1)(B) of the Affordable Care Act amends the Act by adding section 1903(d)(2)(D)(ii) pertaining to overpayments made due to fraud, which is defined in Federal regulations at 42 CFR sections 433.304 and 455.2. Specifically, when a State has been unable to recover overpayments due to fraud within one year of discovery because of an ongoing judicial or administrative process, the State will have until 30 days after the conclusion of judicial or administrative processes to recover such overpayments before making the adjustment to the Federal share. Previously, there had been no specific exception for fraud recoveries in the statute, although Federal regulations at 42 CFR section 433.316 provide that the date of discovery of an overpayment resulting from fraud or abuse is determined differently than for other types of overpayments. As a result of changes under the Affordable Care Act, the discovery date for overpayments due to fraud begins on the date of the final written notice of the State's overpayment determination to the provider.

Section 6402(a) of the Affordable Care Act also addresses overpayments. This provision, which amends the Act by creating a new section 1128J, has no impact on a State's obligations under section 6506 of the Affordable Care Act to return the Federal share. Instead, the new section 1128J(d)(2) of the Act makes explicit that overpayments must be reported and returned to States within 60 days of identification or by the date any corresponding cost report is due, whichever is later. This provision applies to providers of services, suppliers, Medicaid managed care organizations, Medicare Advantage organizations, and Medicare Prescription Drug Program sponsors. It does not apply to beneficiaries.

To the extent there is a conflict with existing regulatory language, the provisions of section 6506(a) of the Affordable Care Act and this guidance supersede the Federal regulations at 42 CFR Part 433 subpart F. We will issue guidance regarding additional aspects of section 6506 in the future, including the requirements of section 6506(b) of the Affordable Care Act to assure the correction of identified claims overpayments with new Medicaid Management Information System edits, audits, and other appropriate corrective action.

We look forward to our continuing work together as we implement this important legislation. If you have questions regarding this information, please contact Mr. Ron Perkins, Director of the Division of Financial Operations, Ronald.Perkins@cms.hhs.gov, or at 410-786-8669.

Sincerely,

/s/

Cindy Mann
Director

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cc:

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