Washington Update

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Agenda

• 2013 political outlook/ACA implementation
• Medicare payment issues
• Federal quality reporting programs
• Compliance
• Administrative Simplification
Political Outlook and Affordable Care Act Implementation
2013 Political Outlook

- 113th Congress – very important issues
- Debt Ceiling
- Budget
- Fiscal Cliff/Sequestration
- SGR
“Fiscal cliff” averted...for now

- “Fiscal cliff”

- The “American Taxpayer Relief Act of 2012”
  - Extended most tax cuts
  - Extended unemployment benefits
  - Sequester cuts postponed for 2 months (including 2% cut to Medicare providers)

- 26.5% cut for 2013 averted
  - MGMA position – repeal the flawed SGR
ACA Implementation

• MGMA’s ACA resource center

• 2013 Medical Device Tax
  – Imposes an excise tax of 2.3% on the sale of any taxable medical device
  – Final rule, IRS information and FAQ

• 2014 Medicaid expansion

• 2014 state implementation of state-based Exchanges
  – Learn more about your state's decision on setting up an Exchange through this state map

• Independent Payment Advisory Board (IPAB): 2015
Medicaid/ Medicare parity

- Raises Medicaid payment rates to Medicare levels in 2013 and 2014
- Increased payments for certain primary care providers for specific services (E&M, vaccine administration, etc.)
  - Eligible specialties: family medicine, general internal medicine, pediatrics (including related subspecialists)
- Physicians must self-attest eligibility based on Board certification or providing 60%+ primary care for Medicaid
- Inconsistent rollout, conflicting information from state Medicaid agencies
- **MGMA resource** on key points of the **final rule**
- MGMA discussions with CMS, letter to National Association of Medicaid Directors
Physician Payment Sunshine Rule

- Applies to payments received from drug and device manufacturers and physician (or family members) ownership in drug and device manufacturers and GPOs
- Payments over $10 (or $100 aggregate during calendar year) must be reported by manufacturers to CMS
- Information will be published on a public website beginning Sept. 2014

<table>
<thead>
<tr>
<th>Examples of Payments Reported</th>
<th>Examples of Payments NOT Reported</th>
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<tbody>
<tr>
<td>Speaking Honoraria</td>
<td>Product samples for patients</td>
</tr>
<tr>
<td>Gifts</td>
<td>Educational materials for patients</td>
</tr>
<tr>
<td>Meals</td>
<td>Discount, including rebates</td>
</tr>
</tbody>
</table>

- MGMA to provide more guidance
- Visit [www.mgma.com/sunshine](http://www.mgma.com/sunshine) for more information
Administrative Simplification

• CMS final regulation for January, 2013 implementation of operating rules for eligibility and claim status make it easier for practice to:
  – Check patient eligibility and financial responsibility
  – Monitor status of submitted claims
  * 90 day enforcement delay: complaints for noncompliance may still be made to CMS

• Interim final rule standardizes electronic funds transfers / electronic remittance advice, IFC on operating rules (Jan. 2014 implementation)
  – New CAQH EFT Enrollment Tool

• Significant fines on health plans for noncompliance

• Action item: assess PM software capability and change if needed
MGMA Advocacy Initiatives

- Advocacy priorities:
  - Repeal the SGR
  - Repeal the IPAB

- Contact Congress Button:
Thank you for posting to your state websites, there is strength in numbers!
Medicare Payment Issues
American Taxpayer Relief Act

- Sets a 2013 conversion factor of $34.0230
- Extends the Medicare 1.0 work RVU GPCI floor through December 31, 2013
- Extends the Medicare therapy cap exception process through December 31, 2013
- Increases the Medicare Part B equipment utilization assumption for advanced imaging services to 90 percent effective for fee schedules established for 2014 and subsequent years, thus reducing future payments
- Increases the Medicare therapy service multiple procedure payment reduction from 25 to 50 percent effective April 1, 2013
Adopts additional Multiple Procedure Payment Reduction (MPPR)

Implements the Value Based Payment Modifier

New therapy reporting requirements

Finalizes a new transitional care management codes

Finalizes changes to the Physician Quality Reporting System (PQRS) and Electronic Prescribing (e-prescribing) Incentive Programs

Complete final rule and impact chart by specialty

MGMA provided comments on the proposed rule, full analysis as a member benefit
Multiple Procedure Payment Reduction

• Per 2012 PFS: MPPR reduces PC payment for second and subsequent certain diagnostic imaging procedures by 25% when performed:
  – On the same patient
  – In the same session
  – By the same physician (or group*)
    • *New in 2013: when furnished by physicians in the same group

• CMS will also apply a MPPR to the TC of certain cardiovascular and ophthalmology diagnostic procedures

• MGMA Comment: CMS does not provide adequate rationale for these payment reductions, and we oppose expanding MPPR to these services
Therapy reporting

New claims-based data collection program for Medicare therapy services

• Voluntary reporting Jan. 1 - Required beginning July 1

• Will collect data on Part B and Comprehensive Outpatient Rehab Facilities benefits regarding patient function & condition related to PT, OT and SLP therapy

• New G-codes and modifiers to be reported at:
  – Outset of therapy;
  – On or before every 10 treatment days; and
  – Time of discharge from therapy

* Functional reporting is also required at the time a patient’s condition changes significantly enough to warrant a re-evaluation
Therapy reporting

- G-codes indicate functional limitation that is the primary reason for treatment
  - See Table 21 for list of G-codes for 2013 claims-based functional reporting

- In addition to functional limitations, therapists must report modifiers indicating severity using a 7-point scale
  - Modifiers: CH-CN to indicate impairment limitation restriction
  - See Table 23 for list of severity/complexity modifiers for reporting for 2013

- G-codes and modifiers must be documented in the medical record

- Reporting must be included on the same claim as a furnished service that Medicare covers, and a $0.00 charge can be added for e/line on the claim that contains the new G-codes
Post Discharge Care Management

- Transitional Care Management (TCM) services following discharge from hospital, skilled nursing facility or community mental health center

- TCM services require communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
  - **99495**: Medical decision making of at least moderate complexity plus a face-to-face visit within 14 calendar days of discharge
  - **99496**: Medical decision making of high complexity plus a face-to-face visit within 7 calendar days of discharge

- Non face-to-face services such as: patient education, assessment and support for treatment regimen adherence and medication management, reviewing discharge information and need for follow-up on pending tests/treatments, assistance scheduling follow-up, communication with home health agencies or other community services utilized by the patient
Post Discharge Care Management

• Only one practitioner may bill the TCM codes for a beneficiary

• Physicians billing for a 10 or 90 day global procedure may not also bill the TCM service for the same Medicare beneficiary

• Medicare TCM can be billed for new or established patients

• Providers allowed to bill for TCM services: primary care physicians, specialists, nurse practitioners, physicians assistants, clinical nurse specialists and certified nurse midwives

• E/M service required for the TCM services cannot be furnished by the same physician on the same day as a discharge management service

<table>
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<tr>
<th>CPT Code</th>
<th>Work RVU</th>
<th>PE RVU</th>
<th>Malpractice RVU</th>
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Federal Quality Reporting Programs
Entering the **penalty** phase

<table>
<thead>
<tr>
<th>Year/Program</th>
<th>eRx</th>
<th>PQRS</th>
<th>Meaningful Use</th>
<th>Value Modifier</th>
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<td>2012</td>
<td>-1.0%</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>2013</td>
<td>-1.5%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2014</td>
<td>-2.0%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2015</td>
<td></td>
<td>-1.5%</td>
<td>-1.0% *</td>
<td>-1.0%</td>
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<tr>
<td>2016</td>
<td></td>
<td>-2.0%</td>
<td>-2.0%</td>
<td>-1.0%</td>
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<tr>
<td>2017 - 2019</td>
<td></td>
<td>-2.0%</td>
<td>-3.0 – 5%**</td>
<td>Amount TBD</td>
</tr>
</tbody>
</table>

* Penalties will be greater for unsuccessful e-prescribers

**Penalty amount could increase up to 5% depending on meaningful use success rates
E-prescribing Program

E-prescribing Bonus 2013

• EP must submit 25 instances of e-prescribing during the calendar year
  ➢ 2013: .5% bonus
• Report using claims, registry, or EHR
• Must have 10%+ of Medicare allowed charges from denominator codes

Denominator Code List:
90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 90862, 92002, 92004, 92012, 92014, 96150, 96151, 96152, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0101, G0108, G0109
2013 eRx Penalty: -1.5%

Avoiding the -1.5% penalty: Providers had to submit at least 10 eligible instances of eRx by 6/30/12 via claims based reporting; OR, submit a hardship exemption request (subject to CMS approval)

Are my providers being penalized?

• Check your RA for reason/remark codes indicating a legislative/regulatory penalty

Appealing a 2013 penalty determination:

• Informal review requests may be submitted no later than Feb. 28, 2013 via email to: eRxInformalReview@cms.hhs.gov

• Include: the individual rendering NPI, contact information (email, telephone, mailing address) and justification for requesting an informal review
Avoiding 2014 eRx Penalty

Two reporting period options

- 6 month reporting (Jan. 1 – June 30, 2013)
  - Report at least 10 instances of eRx; report via claims based reporting only
  - Not restricted to reporting in association w/ a denominator code

- Full year reporting (be a successful e-prescriber in 2012)
  - Report at least 25 eligible instances of eRx; report via claims, EHR or registry

Providers who are not penalized

- New providers (as of June 30, 2013)
- EPs who have a low level of Medicare claims from the denominator set of codes
  (fewer than 100 claims or less than 10% of Medicare allowed charges between 1/1/13-6/30/13)
Avoiding 2014 eRx Penalty

Hardship exemptions:

- Unable to e-prescribe due to local, State or Federal law or regulation
- Prescribed fewer than 100 times during a respective 6 month reporting period
- Providers practicing in areas with limited high-speed Internet (G8642)
- Providers practicing in areas with limited pharmacies with eRx capabilities (G8643)

- Submit hardship exemption request by June 30, 2013
  - Submit request via Quality Reporting Communication Support Page
  - User Manual

- MGMA eRx resources
## eRx program changes

- New hardship exemptions for certain providers who have registered or attested for the meaningful use (MU) program (exemptions are automatic for those who meet the criteria below; no application/request is needed)

<table>
<thead>
<tr>
<th></th>
<th>Exemption #1</th>
<th>Exemption #2</th>
</tr>
</thead>
</table>

**Note:** You must include the full EHR Certification Number in the Registration & Attestation System to get credit for these exemptions
Incentive for 2013: 0.5% bonus

- Report 3 individual measures, or 1 measures group (for individual EPs only) via claims, registry, or EHR
- Available measures: See Tables 95-122
  - 14 new measures for 2013, 14 measures retired
  - CMS measure specification data
- Additional 0.5% for also participating in the Maintenance of Certification Program (MOC)
- Use our new tool! The Interactive PQRS Impact Assessment
PQRS Group Practice Reporting Option, GPRO:

- Open to groups w/ 2 or more providers

- Requires “self-nomination” by Oct. 15, 2013
  - Report via the web (see appendix)

- 2013 GPRO reporting mechanisms:

  1) GPRO registry

  2) GPRO web-interface (25 or more EPs only)

  3) Administrative claims (new!)
2013 PQRS changes

Administrative Claims Option: open to individuals and GPRO, for avoiding the penalty only

• 17 total measures (14 process/ 3 outcome)
  - See tables 123, 124
  - Examples:
    1. Process measure: Lipid profile for patients less than or equal to 75 w/ diabetes; breast cancer screening for women less than or equal to 69
    2. Outcome measure: all cause readmission
Avoiding the 2015 PQRS Penalty:

- 2015 Penalty = **-1.5%**
- 2015 penalty → 2013 reporting period
- Report on 1 measure, or 1 measures group
  - Report via: claims, registry, EHR, GPRO web-interface, or administrative claims
  - No patient volume reporting thresholds required
Where Quality & Cost Meet Payment...
The Value Based Payment Modifier
Value Based Payment Modifier

Groups with 100+ EPs

**Satisfactory PQRS Reporters**
Meet the 2013 criteria for satisfactory PQRS group reporting using GPRO: web-interface, registries, or administrative claims

- **0% Modifier for 2015**
  (No Payment Adjustment)

- **No Election**

- **0% Modifier for 2015**
  (No Payment Adjustment)

**Non-Satisfactory PQRS Reporters**
Groups that do not meet PQRS criteria for 2013

- **-1% Modifier for 2015**
  In addition to the -1.5% PQRS penalty for 2015

**Elect Quality-Tiering**
Groups could (1) earn an upward payment adjustment for high performance OR (2) risk a downward adjustment for poor performance

**2015 Modifier will Adjust**
Either Upward or Downward
-1% would be the maximum downward adjustment for 2015

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Value Based Payment Modifier

Will impact all Part B physicians in 2017

- 2015: Impacts groups with 100+ Eligible Professionals (EPs)
  - EPs include: physicians, nurse practitioners, therapists, physician assistants, clinical nurse specialists and more
  - Based on PECOS query completed by CMS on Oct. 15, 2013

- To avoid 2015 penalty, group must participate in 2013 PQRS GPRO
  - GPRO: Requires self-nomination by Oct. 15, 2013 (includes choosing reporting method)
  - GPRO reporting mechanisms available to groups w/ 100+ EPs=
    1) GPRO registry
    2) GPRO web-interface, or
    3) Administrative claims
What is the Value Modifier score composed of?

1) Quality measures
   • PQRS GPRO measures

2) Outcome measures
   • 3 composite measures on: acute and chronic prevention quality indicators; all-cause readmission

3) Cost measures
   • Total per capita cost (includes Part A and Part B spending), **and** per capita cost for 4 chronic conditions (COPD, coronary artery disease, diabetes, heart failure)
   • Risk adjusted (HCC model)
   • Standardized to eliminate the impact of geographic variation
VBP Modifier: Calculating the VBP score

How will the score be calculated?

Clinical Care
Patient Experience
Population Health
Patient Safety
Care Coordination
Efficiency

Total overall costs for all patients
Total costs for patients w/ 4 chronic conditions

Quality Composite
Cost Composite

Value Modifier Score
### Value Modifier Amounts for the Quality Tiering Approach

<table>
<thead>
<tr>
<th>Quality/Cost</th>
<th>Low Cost</th>
<th>Average Cost</th>
<th>High Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Quality</td>
<td>+2.0X</td>
<td>+1.0X</td>
<td>+0.0%</td>
</tr>
<tr>
<td>Average Quality</td>
<td>+1.0X</td>
<td>+0.0%</td>
<td>-0.5%</td>
</tr>
<tr>
<td>Low Quality</td>
<td>+0.0%</td>
<td>-0.5%</td>
<td>-1.0%</td>
</tr>
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</table>
**Meaningful Use: Stage 1**

Stage 1 core and menu set **MU measures** = 15 core measures, choose 5 of 10 menu set measures

- 6 CQMs (choose 3 core/alternate core + 3 menu set)

Some changes to Stage 1 measures and exclusions made in Stage 2 final rule: [CMS tip sheets](#)

<table>
<thead>
<tr>
<th>Stage 1 Objective</th>
<th>Change</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Record &amp; chart changes in vital signs</td>
<td>Record blood pressure, new age limitations and provider exclusion</td>
<td>2013 optional (req. 2014)</td>
</tr>
<tr>
<td>Public health objectives</td>
<td>Where prohibited, the reporting of these measures are not required</td>
<td>2013 required</td>
</tr>
<tr>
<td>Capability to exchange key clinical information</td>
<td>No longer required</td>
<td>2013 required</td>
</tr>
<tr>
<td>Report ambulatory/hospital CQMs</td>
<td>Objective is incorporated directly into the definition of a meaningful user</td>
<td>2013 required</td>
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</table>
## Meaningful Use Payments

Maximum incentives EPs can earn annually, and over the life of the program

<table>
<thead>
<tr>
<th>Calendar Year</th>
<th>2011</th>
<th>2012</th>
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<tbody>
<tr>
<td>2011</td>
<td>$18k</td>
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<td>2016</td>
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<tr>
<td>Total</td>
<td>$44k</td>
<td>$44k</td>
<td>$39k</td>
<td>$24k</td>
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</table>
Meaningful Use: Stage 2

• Stage 2 final rule released Aug. 2012, along with factsheet
• Stage 2 = 2014
• 17 core measures / 3 out of 6 menu measures required
• Key changes:
  – Must report CQM data electronically, starting in 2014
  – Patient engagement measures
  – Batch reporting in 2014
• MGMA /CMS stage 2 webinar, MU resource center
### Meaningful Use Penalties

#### Avoiding MU Penalties

- Providers who are eligible to earn an incentive must participate successfully beginning in 2013 (or 2014 in some cases) to avoid the -1% penalty in 2015
- 5 hardship exemptions:
  1. **Infrastructure** - i.e. lack of broadband
  2. **New EPs** – limited 2 yr exempt. for newly practicing EPs
  3. **Unforeseen circumstances** - i.e. natural disaster
  4. Lack of face-to-face or telemedicine interactions and follow-up visits with patients
  5. EPs who practice at multiple locations (must demonstrate you lack control over availability of the CEHRT for >50% of patient encounters)

*Those with a primary specialty of anesthesiology, radiology or pathology will not be subject to penalties and do not have to apply for a hardship exemption*
Compliance
Omnibus Privacy and Security Final Rule

Published Jan. 25, key provisions include:

• **Breach Notification “harm standard” replaced** – practices required to presume a reportable breach unless a risk assessment is conducted and proves a low risk to PHI

• **Changes to rules governing the sale of PHI or use for marketing/fundraising**

• **Business Associates (incl. subcontractors) now considered “covered entities”** - must abide by all privacy & security requirements & face fines if they don’t
  – Practices may be subject to enforcement for violations caused by their BAs

• If practice stores PHI electronically, patient has a right to ask for it electronically

• Self-pay patients can require that PHI must not be disclosed to plans
Steps Practices Will Need to Take

• Revise your Notice of Privacy Practices
  – Post revised Notice (prominent place and on website, give to all new patients)

• Review & revise all BA agreements
  – Look for additional OCR guidance
  – New OCR sample BA agreement

• Incorporate a “segmenting” approach to self-pay patient PHI
  – Ensure that this PHI isn’t given to the plans during an audit

• Explore options for providing your patients an electronic copy of the PHI

• Develop comprehensive breach avoidance & notification policies & procedures

• Conduct a thorough security risk assessment
  – At mgma.com/hipaa - review the NIST checklist, look for MGMA tool in the coming months

• Compliance required for most provisions by Sept. 23!
ICD-10

CMS finalized additional compliance delay:
- MGMA advocacy resulted in CMS delay of implementation to Oct. 1, 2014
- Vastly more complex diagnosis code system

To date the government has failed to meet MGM criteria:
- demonstrate how the benefits outweigh significant costs
- pilot test the new code set
- consider alternative approaches

MGMA ICD-10 resources
Thank you!

Q&A
Appendix
## Table Reference Guide

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<thead>
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<th>Table #</th>
<th>Table</th>
<th>Fee Schedule Page #</th>
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<td>Impact on Total Allowed Charges by Specialty</td>
<td>69344 - 69345</td>
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<td>12</td>
<td>Diagnostic Cardiovascular Services Subject to the Multiple Procedure Payment Reduction</td>
<td>68942 - 68943</td>
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<td>Diagnostic Ophthalmology Services Subject to the Multiple Procedure Payment Reduction</td>
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<td>G-Codes for Claims-Based Functional Reporting</td>
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<td>Severity/Complexity Modifiers</td>
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<td>Individual PQRS Quality Measures</td>
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<td>PQRS GPRO Web-Interface Quality Measures</td>
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<td>PQRS Measures Groups</td>
<td>69273 - 69283</td>
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<td>124</td>
<td>Admin. Claims Outcome Measures for EPs &amp; Group Practices</td>
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MGMA Fee Schedule Analysis Tool

New MGMA fee schedule analysis tool allows you to compare the new fee schedule to the old fee schedule.

Upload CPT codes for the providers in your practice, and the tool will calculate the changes in work and total RVU values using the new and current fee schedules.

Questions? Contact surveys@mgma.com
The Patient Protection and Affordable Care Act was upheld by the Supreme Court of the United States, with modifications relating to Medicaid expansion requirements in the law.

Medicaid expansion: states have choice

- Variability in state implementation of Medicaid expansion

SCOTUS decision analysis by MGMA’s Washington Counsel

Final rule on Medicaid expansion under ACA
Longer-Term ACA Payment Reforms

- Medicare Shared Savings Program (ACO): 2012
- National pilot program on payment bundling: 2013
- Value-based payment modifier: 2015
- Centers for Medicare & Medicaid Innovation (CMMI)
  - Advanced Payment ACO model
  - Bundled Payment for Care Improvement Initiative
  - Others… For more information visit: [http://www.innovations.cms.gov](http://www.innovations.cms.gov)
Steps for 2013 PQRS GPRO Self-Nomination/Registration

**Period I: December 1, 2012 – January 31, 2013**

1. Sign-in to the Physician and Other Health Professionals Quality Reporting Portal with an Individuals Authorized Access to CMS Computer Services (IACS) account

2. Click the “Create Self Nomination Request” link located on the left side of the web page. This will take you to the self-nomination screens on the Communication Support Page

3. Select “Group Practice Reporting Option {Group Practice}” as the requestor type and hit “submit.” Fill out the required fields on the screens that follow. See the user manual for additional information or click the Help icon

**Period II: CMS plans to open a second Self-Nomination/Registration period in the summer time frame (July- Oct. 15, 2013)**
Rule’s definition of “breach”:

“[A]n acquisition, access, use, or disclosure of protected health information in a manner not permitted under subpart E is presumed to be a breach unless the covered entity or business associate, as applicable, demonstrates that there is a low probability that the protected health information has been compromised based on a risk assessment of at least the following factors:

(i) The nature and extent of the protected health information involved, including the types of identifiers and the likelihood of re-identification;

(ii) The unauthorized person who used the protected health information or to whom the disclosure was made;

(iii) Whether the protected health information was actually acquired or viewed; and

(iv) The extent to which the risk to the protected health information has been mitigated.”
The proposed rule clarifies details concerning a provider’s obligation to report and return overpayments pursuant to ACA

- However, even without a final regulation, providers are subject to the statutory requirements now

- The **proposed rule** specifies that:
  
  - Overpayments must be reported if they are identified within 10 years of being received
  
  - A provider will have “identified” an overpayment if s/he has actual knowledge of its existence or acts in reckless disregard or deliberate ignorance of its existence
  
  - A provider has **60 days to report and return an overpayment if, after reasonable inquiry, the provider determines an overpayment exists**

- [MGMA analysis](#) of 60 Day Overpayment Rule