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Health & FDA Business | Alert

September 2015

Court Holds Late Re-Payments To Medicare Or Medicaid Trigger False Claims Act Penalties

Most health care providers are familiar with the False Claims Act (FCA) and its draconian penalties for improper Medicare and Medicaid claims. The FCA though actually is a two-edged sword and either edge potentially can be extremely costly. The first edge is well-known: file a claim that turns out to be less than truthful and risk paying significant penalties. The second edge is somewhat more obscure but potentially more devastating: if you owe the government money and knowingly fail to repay or attempt to conceal the debt, then you have also violated the FCA. In the health care sector, there is an added twist to this obligation to repay. Specifically, the Affordable Care Act (ACA) requires a person who receives an overpayment of Medicare or Medicaid funds to "report and return" the overpayment to HHS, the state, or another party if appropriate.[1] The statute sets a deadline for such reporting and returning: an overpayment must be reported and returned within 60 days of the "date on which the overpayment was *identified*" (the "60-day rule" or "report and return" provision), and any overpayment retained beyond that point constitutes an "obligation" carrying liability under the FCA.

In *United States ex rel. Kane v. Continuum Health Partners*, Inc.,[2] a case that has drawn national attention and has been closely watched by hospitals and other health care providers, the court was asked to decide when that 60-day clock begins to run. In *Continuum Health*, a group of hospitals were overpaid starting in 2009 by a Medicaid Managed Care Organization (MCO) due to a computer error by the MCO's outside contractor. According to the Department of Justice's (DOJ) complaint, in September 2010, the New York State Comptroller's Office raised questions with Continuum about the overpayments. In late 2010 and early 2011, Continuum assigned an employee, Robert Kane, to ascertain which claims had been overpaid by Medicaid. In January 2011, the Comptroller's Office notified Continuum of additional Medicaid overpayments. In February 2011, Kane sent an email to Continuum's management with a spreadsheet indicating

[1] 42 U.S.C. § 1320a-7k(d)(1).

[2] No. 11-cv-02325-ER. U.S. District Court, Southern District of New York, (Aug. 3, 2015).

overpayments of approximately $1 million that had been received by Continuum's hospitals. Four days later, Continuum terminated Kane's employment.

From March 2011 to February 2012, the Comptroller notified Continuum of additional Medicaid overpayments. In June 2012, the federal government issued a Civil Investigation Demand (CID) which allegedly resulted in Continuum's reimbursing Medicaid for 300 claims. Although Continuum made "piecemeal" repayments to Medicaid, it did not complete repayment until March 2013.

Kane commenced a whistleblower suit under the FCA and New York's False Claims Act in April 2011 naming Continuum and its hospitals, as well as numerous other hospitals and providers that allegedly received these overpayments and failed to timely report and return them. In June 2014, the DOJ and the New York Attorney General's Office intervened as plaintiffs in Kane's whistleblower suit, but only against Continuum, Beth Israel Medical Center, and St. Luke's/Roosevelt Hospital. The DOJ and the Attorney General are seeking treble damages and a penalty of between $11,000 and $12,000 for each overpayment under their respective false claims statutes.

Continuum and its hospitals moved to dismiss, arguing that Kane's email only provided notice of *potential* Medicaid overpayments rather than actual overpayments. The government countered that Kane's email and spreadsheet properly identified Medicaid overpayments that turned into violations of the FCA when they were not reported and returned to Medicaid within the statutory 60-day period.

Defendants argued to dismiss, arguing among other things that the word "identified" means "classified with certainty," and that since Kane had not classified the amounts as definite overpayments, the 60-day clock was not triggered by Kane's email. The district court, in a carefully crafted 44-page decision, rejected the defendants' argument, characterizing their interpretation of the 60-day repayment requirement as an "absurdity," and declaring that it "would make it all but impossible to enforce the reverse false claims provision of the FCA in the arena of health care fraud." The court explained:

> Congress intended for FCA liability to attach in circumstances where, as here, there is an established duty to pay money to the government, even if the precise amount due has yet to be determined. Here, after the Comptroller alerted defendants to the software glitch and approached them with specific wrongful claims, and after Kane put defendants on notice of a set of claims likely to contain numerous overpayments, defendants had an established duty to report and return wrongfully collected money.

The court continued:

> Under the defendants' framework, their obligation to pay would not be triggered until *after* they had done the work necessary to determine conclusively the precise amount owed to the government, thus creating a perverse incentive to delay learning the amount due and relegating the 60-day period to merely the time within which they would have cut the check. This is likely not what Congress intended.

<u>Lessons</u>

The court's decision was on a motion to dismiss, wherein the court must interpret the facts in a light favorable to the DOJ, and the defendants will have the right to present their own version of events at later stages of the proceeding. Nonetheless, there are important lessons from this case and the court's decision.

1. That these defendants were targeted by the DOJ and New York State for such a high-profile lawsuit is due at least in part to the government's contention that they were informed about the Medicaid overcharges by the state Comptroller's office (several times), as well as by Kane's internal audit report, and by the government's CID, yet they still took two years to complete the identification and return of the

overpayments.

2. Any health care provider that has billed Medicare and Medicaid is aware of how complicated it can be to determine whether the bills are accurate and whether the provider has been underpaid or overpaid by those programs for medical services provided to program beneficiaries. Sixty days may not be enough time for a provider to determine with certainty whether an overpayment has been made. Nonetheless, when a potential overpayment is identified either through a provider's internal claims review process or by notification from a payor or government agency, the provider must promptly investigate to determine if an overpayment has in fact occurred, and report and return it within the statutory 60-day period.

3. The court noted that the FCA contains "no language to temper or qualify this unforgiving [60-day repayment] rule..." Nonetheless, it did elicit from DOJ attorneys an admission that:

> [T]his is not a question... of a case where the hospital is diligently working on the claims and it's on the sixty-first day and they're still scrambling to go through their spreadsheets, you know, the government wouldn't be bringing that kind of [FCA] claim." The court then characterized such a situation as one in which "... the provider would not have acted with the reckless disregard, deliberate ignorance, or actual knowledge of an overpayment required to support an FCA claim."

4. Providers that learn that they may have to return a significant overpayment to Medicare or Medicaid should consider making a voluntary disclosure and let the government know the steps the provider is taking to identify the cause and the approximate amount of the overpayment. Depending upon the amount of the overpayment, it may be advisable to do what is done in certain income tax cases: make a repayment of the estimated overpayment to stop the 60-day requirement from turning it into a potential FCA claim, and then seek a refund or credit at a later date after the actual amount of the overpayment has been settled. While this will result in the potential for tying up a provider's funds, it is certainly preferable to incurring the draconian liability and penalties of the FCA.

The decision, many would argue, provides the Centers for Medicare & Medicaid Services (CMS) a legal basis, albeit limited to single district, for its yet-to-be-finalized regulations on returns of overpayments, which were proposed more than three years ago.[3] The proposed rule would adopt for Medicare providers and suppliers the same definition of "identified" that was previously applied to Medicare Parts C and D: viz. when a provider "has actual knowledge of the overpayment or acts in reckless disregard or deliberate ignorance of the overpayment." CMS explained that this definition would give providers and suppliers "... an incentive to exercise reasonable diligence to determine whether an overpayment exists." CMS continued:

> Without such a definition, some providers and suppliers might avoid performing activities to determine whether an overpayment exists, such as self-audits, compliance checks, and other additional research.

In any event, this court decision gives a significant boost to enforcement of the 60-day repayment requirement by the government, whistleblowers, and third party payors that operate Medicare and Medicaid managed care plans. Providers who ignore the 60-day repayment requirement do so at considerable peril to themselves.

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[3] 77 Fed. Reg. 9179-9187 (Feb. 16, 2012).

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