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Expert Analysis

Feds Target Untimely Repayments To Medicare and Medicaid

By
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In an earlier column[1] summarizing the enhanced anti-fraud provisions enacted in 2010 as part of the Patient Protection and Affordable Care Act (ACA), reference was made to an important provision requiring any person or entity that receives payments from Medicare or Medicaid to disclose and return, within a specified time period, any overpayments that may have been made by those government programs. Four years later, the Department of Justice—apparently for the first time—has intervened in a whistleblower lawsuit in New York alleging that the failure of some hospitals to return Medicaid overpayments within the required time period violates the False Claims Act (FCA)[2] and triggers the FCA's draconian financial penalties.

Background

The FCA imposes fines and penalties when an individual or entity:

> …knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the government, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the government.[3]

Thus, for example, when a provider, such as a hospital, knowingly submits a false cost report to Medicare, or when a medical group knowingly submits improper bills to Medicaid, such actions are violations of the FCA. It matters not if a false bill is ever even paid; the mere submission of the false bill violates the FCA.

Indeed, it is not even necessary to prove a specific intent to violate the FCA. The FCA defines knowledge very broadly:

> …the terms "knowing" and "knowingly"—
>
> (A) mean that a person, with respect to information—
>
> (i) has actual knowledge of the information;
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> (ii) acts in deliberate ignorance of the truth or falsity of the information;
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> (iii) acts in reckless disregard of the truth or falsity of the information; and
>
> (B) require no proof of specific intent to defraud….[4]

In the past, if a provider was overpaid due to an inadvertent mistake in a bill, or if Medicare or Medicaid mistakenly made an overpayment, many providers would eventually refund the overpayment once it was discovered and verified. However, many other providers would simply keep the overpayment instead of refunding it, in the expectation that the program would never catch the error. If a Medicare carrier or intermediary or a Medicaid auditor later discovered the overpayment, it would often simply demand repayment of the amount with interest or deduct the overpayment and any interest from future payments to the provider. Nonetheless, the Medicare and Medicaid programs have continued losing billions of dollars in undetected overpayments.

In enacting the ACA, Congress was determined to implement stronger measures to curb such abuses, and to incentivize all those who receive program funds to track overpayments and promptly refund them. Accordingly, the ACA defined the term "overpayment" for purposes of the FCA as:

> …any funds that a person receives or retains under Title XVIII [Medicare] or XIX [Medicaid] to which the person, after applicable reconciliation, is not entitled….[5]

The failure to return known overpayments of government funds has come to be known as a "reverse false claim."

The ACA requires that anyone who receives any kind of overpayment from Medicare or Medicaid must report and return the overpayment, and give notice in writing as to the reason for the overpayment.[6] The overpayment must be reported and returned by the recipient within 60 days after the date on which the overpayment was identified, or the date that the corresponding cost report was due, whichever is later.[7]

> The ACA classifies any overpayment identified and retained by the recipient after the deadline for reporting and returning the overpayment as a violation of the FCA.

Again, it does not matter whether the overpayment was intentional or unintentional, or even if it resulted from an error by the Medicare or Medicaid programs or their respective contractors. The ACA specifically classifies any overpayment identified and retained by the recipient

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after the deadline for reporting and returning the overpayment as a violation of the FCA.[8] The penalties for violating the FCA include treble the amount of the overpayment, plus a fine of $5,500 to $11,000 per claim, civil monetary penalties, as well as potential suspension or exclusion from participation in Medicare and Medicaid.[9]

Lawsuit

The complaint filed by the U.S. attorney for the Southern District of New York in the FCA lawsuit alleges that Beth Israel Medical Center, St. Luke's-Roosevelt Hospital Center, and Long Island College Hospital (at the time all under a corporate parent known as Continuum Health Partners) contracted with a Medicaid managed care plan, Healthfirst (the plan) to provide services to the plan's Medicaid beneficiaries. The hospitals were supposed to accept what the plan paid them as full payment for the services they provided to the plan's members, and were not permitted to seek additional payments from Medicaid. However, from early 2009 to late 2010, the Continuum hospitals allegedly submitted claims to Medicaid for additional payments for those same services due to erroneous coding that turned up in electronic remittances issued by the plan.

The government contends that the New York State comptroller's office, one of the agencies that monitors questionable Medicaid payments, notified Continuum that certain claims submitted for its hospitals' services were wrongly billed to Medicaid. An internal investigation undertaken by a Continuum employee, Robert Kane, uncovered the much larger extent of the overbilling to Medicaid: approximately 900 claims totaling over $1 million.

Instead of returning all of the overpayments within the required 60 days after they had been identified, Continuum allegedly repaid them only in small batches. Some of the piecemeal repayments, which took place over more than two years, occurred only when overpayments were actually brought to Continuum's attention by the state comptroller. The government contends that the repayments for more than 300 of the overpayments were made only after issuance of a federal civil investigative demand in June 2012, and that Continuum didn't complete repayment until March 2013.

In February 2011, Kane was terminated from his employment. (The court papers do not indicate if his termination was in any way related to the Medicaid overpayment matter). In April 2011, Kane filed under seal a qui tam suit[10] under the FCA and the state False Claims Acts of New York and New Jersey. Defendants named included Healthfirst, and nearly 100 hospitals and providers in New York and New Jersey, including Continuum, Beth Israel, St. Luke's-Roosevelt, and Long Island College Hospital.

On June 27, 2014, the U.S. Attorney's Office partially intervened in the Kane lawsuit by filing its own complaint[11] naming Continuum, Beth Israel, and St. Luke's-Roosevelt as defendants.[12] The lawsuit cited the Continuum hospitals' failure to timely repay the Medicaid amounts they had received in excess of what the plan had paid them. It seeks treble the amount of the overpayment, the maximum fine of $11,000 per unrefunded claim, other penalties, and the government's costs related to bringing the suit.

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In its intervention suit, the government does not contend that the erroneous bills to Medicaid were the hospitals' fault or violative of the FCA. That Continuum and its hospitals were targeted by the U.S. Attorney's Office in such a high-profile lawsuit is probably attributable to the government's claim that the defendants were informed about the alleged Medicaid overcharges by the state comptroller's office (several times), by the internal investigation performed by Kane, and by the civil investigative demand, yet still took two years to complete the identification and return of the overpayments received.

The New York Attorney General's office also has intervened in the case and apparently will be pursuing fines and penalties for the same overpayments under New York's False Claims Act.[13] As the underlying whistleblower suit proceeds, other hospitals that delayed returning overpayments to Medicaid may find themselves targeted by the U.S. attorney and the attorney general for reverse false claims lawsuits.

Lesson

Anyone who has been involved in Medicare and Medicaid billing problems is aware of just how complicated it can be to sort out whether a provider has properly or improperly billed and been paid for medical services. For decades, disputes over whether a provider had been properly paid by Medicare or Medicaid could go on for years, with the process involving negotiations with carriers and intermediaries, hearings before the Provider Reimbursement Review Board or state agencies, litigation, appeals, and so on. When an overpayment had been finally adjudicated—which could take years—the government or its contractor would assess interest on the overpayment for the duration that the overpayment had been retained.

That relatively benign scenario was upended with the ACA's enactment, and the classification of any identified and retained overpayments as reverse false claims violative of the FCA. Accordingly, any provider, payor, contractor, or other recipient of Medicare or Medicaid funds must conscientiously monitor and account for such funds. When a potential overpayment is identified either through internal review or external notification, the entity must promptly determine if an overpayment was in fact made, and report and return it to the appropriate program or contractor within the 60-day period or when the corresponding cost report is due, whichever is later.

When in doubt, and depending upon the amount in question, it may be advisable to do what is done in certain income tax cases: make the repayment and then seek a refund or credit at a later date after the legitimacy of the payment has been resolved. While this will result in the potential for needlessly tying up funds, it is certainly preferable to incurring the potentially ruinous liabilities and penalties of the FCA.

1. Serbaroli, "Health Care Reform Law's Anti-Fraud Provisions," NYLJ, May 25, 2010, p. 3.
2. 31 U.S.C. §3729 et seq.
3. 31 U.S.C. §3729(a)(1)(G).
4. 31 U.S.C. Sec. §3729(b)(1).
5. 42 U.S.C. Sec. §1320-7k(d)(4)(B).
6. 42 U.S.C. Sec. §1320a-7k(d)(2).
7. 42 U.S.C. §1320a-7k(d)(2).
8. 42 U.S.C. Sec. §1320a-7k(d)(3).
9. On May 12, 2014, the Office of Inspector General (OIG) of the U.S. Department of Health and Human Services issued a proposed rule that would amend the OIG's civil monetary penalty rules to impose a default penalty of $10,000 per day for each day beyond the statutory time period that a person or entity fails to report and return an overpayment. 79 Federal Register 27079.
10. *United States ex rel. Kane vs. Healthfirst*, Civil Action No. 11-2325 (ER), S.D.N.Y., April 5, 2011; amended complaint filed May 15, 2014.
11. *United States v. Continuum Health Partners*, Civil Action No. 11-2325(ER), S.D.N.Y., June 27, 2014.
12. Long Island College Hospital had been transferred to the State University of New York and had closed in May 2014.
13. N.Y. Finance Law §194.