New York Law Journal
SERVING THE BENCH AND BAR SINCE 1888
WWW.NYLJ.COM
An ALM Publication
VOLUME 254—NO. 57
TUESDAY, SEPTEMBER 22, 2015

Health Law

Expert Analysis

Court Upholds False Claims Act Suit Over Late Repayments to Medicaid

By
Francis J. Serbaroli

In an earlier column,[1] we reported on the intervention by the Department of Justice and New York Attorney General in a high-profile whistleblower suit against hospitals that allegedly failed to repay Medicaid overpayments on a timely basis. The hospitals moved to dismiss the suit, and a federal court has now issued a decision that should be of interest to every health care provider that participates in Medicare, Medicaid or any other government health benefit program.

Background

By now, most health care providers are familiar with the federal False Claims Act (FCA)[2] and its draconian penalties for improper Medicare and Medicaid claims. A so-called "reverse false claim" occurs when a provider owes money to Medicare or Medicaid and knowingly fails to repay or attempts to conceal the debt. When the Affordable Care Act (ACA) was enacted, it added a new obligation requiring that a person receiving an overpayment from Medicare or Medicaid "report and return" the overpayment to the Department of Health and Human Services, the state, or other appropriate party "within 60 days of the date on which the overpayment was identified."[3] The statute states that an overpayment retained beyond 60 days constitutes a violation of the FCA.

Beginning in 2009, a large number of hospitals and other healthcare providers in the New York City area received overpayments from a Medicaid managed care organization (MCO) due to a computer error by the MCO's outside claims processing contractor. 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) were among the many providers that received these overpayments.

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. Four days after Kane emailed a spreadsheet detailing these overpayments to Continuum executives, Kane's employment was terminated.

A 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.

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 re-payment until March 2013.

In April 2011, Kane filed under seal a qui tam suit[4] under the FCA and the state false claims acts of New York and New Jersey. Defendants named included the MCO, 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[5] naming Continuum, Beth Israel, and St. Luke's-Roosevelt as defendants.[6] The lawsuit cited the Continuum hospitals' failure to timely repay the Medicaid amounts they had received in excess of what the MCO had paid them. It seeks treble the amount of the overpayment, the maximum fines of $11,000-$12,000 per un-refunded claim, other penalties, and the government's costs related to bringing the suit.

Continuum and its hospitals moved to dismiss, arguing that Kane's email and spreadsheet 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.

In their motion papers, defendants argued, among other things, that the word

FRANCIS J. SERBAROLI *is a shareholder in Greenberg Traurig and the former vice chair of The New York State Public Health Council.*

"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 Southern District of New York, 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.

Lessons

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

1. That these defendants were targeted by the Justice Department 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 should 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 Justice Department 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 liabilities and penalties of the FCA.

This court decision, many would argue, provides the Centers for Medicare & Medicaid Services (CMS) a legal basis, albeit limited to a single district, for its yet-to-be finalized regulations on returns of overpayments, which were proposed more than three years ago.[7] 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.

1. "Feds Target Untimely Repayments to Medicare and Medicaid," New York Law Journal, Sept. 23, 2014, p. 3.
2. 31 U.S.C. §3729 et seq.
3. 42 U.S.C. §12201-7k(d)(1).
4. *United States ex rel. Kane v. Healthfirst*, Civil Action No. 11-2325 (ER), S.D.N.Y., April 5, 2011; amended complaint filed May 15, 2014.
5. *United States v. Continuum Health Partners*, Civil Action No. 11-2325(ER) (S.D.N.Y., June 27, 2014).
6. Long Island College Hospital had been transferred to the State University of New York and had closed in May 2014.
7. 77 Fed. Reg. 9179-9187 (Feb. 16, 2012).