GT GreenbergTraurig

Beware of Collateral Fallout in Medicare/Medicaid Fraud Settlements

In his Health Law column, Francis J. Serbaroli discusses additional liabilities that lawyers should be aware of when settling Medicare or Medicaid fraud cases for their clients. He explains some of the additional weapons that the federal and state governments can deploy against clients after a settlement is finalized.

By Francis J. Serbaroli | May 16, 2022 | New York Law Journal

Audits and investigations into potentially inaccurate or improper Medicare or Medicaid claims can be prolonged, contentious, expensive, and messy. The government agency (or government contractor) involved can demand and scrutinize voluminous amounts of bills, medical records, and business documents, and can conduct extensive interviews with the target's executives and employees. There are often disagreements as to the meaning of Medicare and Medicaid laws, regulations, and billing rules.

Investigators and auditors can pick and choose a sampling of bills and then extrapolate the statistical result to the universe of bills for a particular time period, and come up with what is often an extravagant claim for repayment. The billing samples and statistical calculations are examined and then challenged. At the end of this long, tortuous road, a settlement agreement can be reached whereby the entity that submitted the claims agrees to re-payment of inaccurate,

improper, or questionable claims, the payment of applicable fines, penalties and interest, and possibly submits to compliance and reporting requirements for a period of time.

The government's weapons of choice in most audits and investigations are the federal False Claims Act (31 U.S.C. §§3729 et seq.), and in New York, the state False Claims Act (State Finance Law §§187 et seq.). We have written extensively in this column about these broadly worded statutes and their potentially ruinous fines, penalties, and repayment terms. Liability attaches under these laws if the entity or person submitting the bills knows or acts in reckless disregard of the truth or falsity of the bills. The federal and state statutes specifically state that no proof of a specific intent to defraud is required. Many entities caught up in False Claims Act audits and investigations, even if they unintentionally violated the statutes, end up settling with the government rather than risking prolonged, expensive, and reputation-damaging litigation, and the possible imposition of draconian penalties.

After such a settlement, lawyers without sufficient experience in health care may conclude that the matter is over, and congratulate themselves on a job well done. But not so fast! This column will address some of the collateral fallout that can occur after the settlement documents have been executed, and any restitution, fines & penalties have been agreed upon.

Criminal Proceedings

There are all kinds of forms submitted by Medicare and Medicaid participating providers that require attestation "under penalty of perjury." These forms include applications to become participating providers, cost reports, certifications by contractors with Medicare and Medicaid managed care plans that the contractors are in compliance with applicable laws and regulations, and many others. In addition, a government agency such as the U.S. Department of Justice (DOJ) may, in the course of an investigation, issue a Civil Investigative Demand (CID) in order to gather documents and information. The law authorizing CIDs requires certifications under oath and under penalty of perjury that documentary material submitted in response to the CID is accurate and complete. 31 U.S.C. §3733(f).

It does not happen often, but after a settlement of a False Claims Act case, the government can bring a separate criminal prosecution against an entity or individual that submitted false information or falsely certified a document under oath. In addition to perjury, old chestnuts like obstruction of justice, obstructing governmental administration, and related laws could be implicated in a perjury prosecution.

Program Exclusion

Another of the most dangerous weapons in the anti-fraud arsenals of the Medicare and Medicaid programs is the government's ability to exclude entities and individuals from being participating providers in those programs. For individuals, such an exclusion is often referred to as the career equivalent of the death penalty since it makes an individual virtually unemployable in the health care sector. An excluded entity for the most part has to get out of the health care sector or even go out of business.

In 2007, in the earlier wave of opioid scandals, the president, general counsel, and medical director of Purdue Pharma subsidiary Purdue Frederick, the maker of the time-release opiate Oxycontin, pled guilty to misdemeanor counts in connection with charges that the subsidiary had illegally marketed Oxycontin to physicians and patients as being less addictive and less subject to abuse. None of these individuals were alleged to have had personal knowledge of the corporate wrongdoing, but they nevertheless were "responsible corporate officers" who each had "responsibility and authority to prevent in the first instance or to promptly correct" the misbranding. The three executives were each sentenced to three years probation, 400 hours of community service, a $5,000 fine, and disgorgement of a total of $36.5 million in compensation that had been paid to them during the period that the drug misbranding took place.

After the criminal charges were resolved, the Office of Inspector General (OIG) of the U.S. Department of Health and Human Services (HHS) successfully moved to exclude all three executives from participation in Medicare, Medicaid, and other federal health care programs. The exclusions were challenged administratively and in court, and while the various exclusion periods were adjusted, they were upheld on appeal.

The exclusion penalty can be applied by HHS to both Medicare and Medicaid participants. States can impose their own Medicaid exclusion penalties. For example, if HHS imposes a three-year Medicare or Medicaid exclusion penalty, the state Medicaid program can impose an even longer Medicaid exclusion period. When the exclusion period expires, the excluded entity or individual is not automatically restored to participating provider status, but must re-apply to be a participating provider. It is then within the discretion of HHS and the state Medicaid program to grant or reject such re-application.

False Statements Law

New York, in addition to its own False Claims Act, has an obscure statute, Social Services Law §145-b, that prohibits false statements or representations in obtaining payment from public funds "for services or supplies furnished or purportedly furnished pursuant to this chapter." The Social Services Law is one of the laws governing the administration of New York's Medicaid program and a variety of other program funding for the elderly, handicapped, special populations, and others. Penalties for violating this law include:

… three times the amount by which any figure is falsely overstated or in the case of non-monetary false statements or representations, three times the amount of damages which the state, political subdivision of the state or entity performing services under contract to the state or political subdivision of the state sustain as a result of the violation or five thousand dollars, whichever is greater.

The statute also provides penalties for substandard or unnecessary care provided to Medicaid beneficiaries.

Character and Competence

The New York State Department of Health (DOH) does extensive background research on anyone who applies to be an owner, operator, investor, or governing board member of health care facilities that are licensed under Public Health Law (PHL) Article 28 (hospitals, nursing homes, diagnostic & treatment centers, ambulatory surgery centers, etc.), Article 36 (certified and licensed home health agencies), and other licensing statutes. A Medicare and Medicaid fraud settlement can result in debarments by DOH of the corporate entity and its owners and executives from ownership, operation, or governing body membership in other New York-licensed health care facilities.

For example, if the owner of a home health agency that has been a party to a Medicare or Medicaid fraud settlement subsequently files a certificate of need (CON) application to establish an ambulatory surgery center in New York or even to become the owner of an existing ambulatory surgery center, the DOH can reject that owner's CON application under the "character and competence" provision of PHL §2801-a(3). Accordingly, it is important to ascertain whether entering into a settlement agreement in a Medicare or Medicaid audit or investigation will result in debarment from owning, operating or serving on the governing board of a licensed health care facility *before* entering into the settlement agreement.

Press Release and News Conference

In many cases, the government agency that conducted the audit or investigation will issue a press release and possibly hold a press conference trumpeting the terms of the executed settlement agreement to the media. These press releases are inevitably self-congratulatory (even when the investigation arose as a result of a private whistleblower's tip or qui tam lawsuit, and not the agency's own diligence), but they are also often misleading and can be downright inflammatory in their wording. As noted earlier, the Medicare and Medicaid laws, regulations, billing and payment rules can be notoriously and unnecessarily complicated. Misunderstanding and disagreement over their wording and meaning, and the resulting disputed bills, cost report errors, and overpayments, often do not necessarily rise to the level of "fraud" simply because the investigating agency has the authority to investigate and prosecute fraud, or has the word "fraud" in the agency's name.

Conclusion

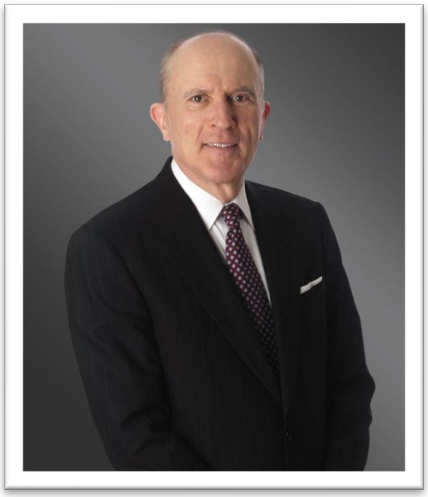
There is no question that fraud is a huge problem for Medicare, Medicaid, and other government medical benefit programs (and for private health insurers as well), and has been for decades. Government estimates put the fraud problem at a staggering 10% or more of healthcare expenditures. Fraud drains precious dollars from the health care system, raises both the cost of medical services and the costs of coverage, results in unneeded health care services to patients, and needs to be rooted out and punished. What constitutes actual fraud, however, can be quite different from errors or misunderstandings of the complex laws, regulations and billing rules for government health benefit programs.

Lawyers representing clients in the course of Medicare and Medicaid audits and investigations must be aware of every potential criminal, civil and administrative liability that should be

included and resolved in a universal settlement agreement. They must be aware that, even when they persuade the government not to fire one its guns at their client, there may be other guns pointed and ready to be discharged at the same target.

About the Author:

Francis J. Serbaroli is a shareholder in Greenberg Traurig and the former vice chair of the New York State Public Health Council.



serbarolif@gtlaw.com