Reporting and Returning Overpayments: Complications, Risks, and Headaches Under PPACA

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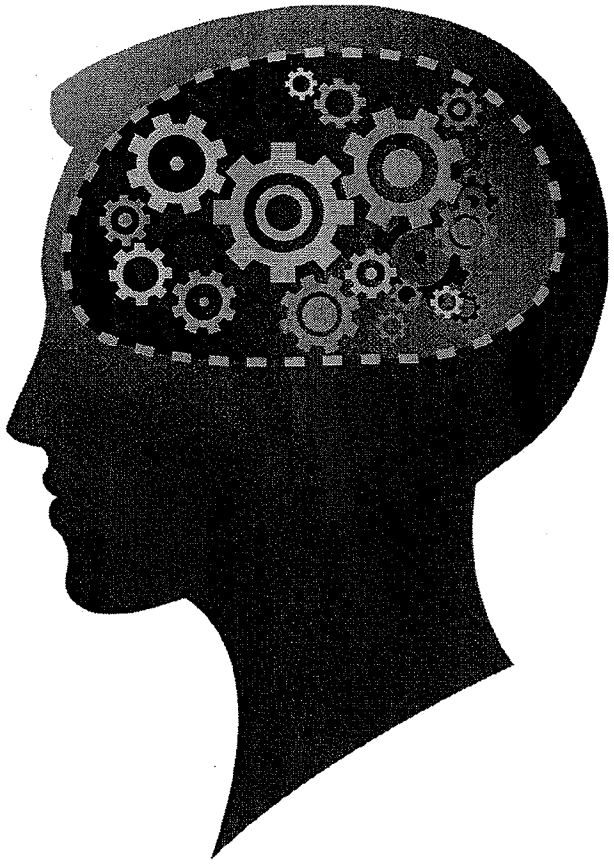


Introduction

In Fiscal Year 2011, the U.S. Department of Justice recovered more than $3 billion as a result of False Claims Act (FCA) settlements and judgments. Healthcare recoveries accounted for 83% ($2.5 billion) of that total.[1] On September 7, 2011, DOJ arrested ninety-one people in eight states and charged them with attempting to steal $295 million from Medicare in what was the largest Medicare arrest to date.[2] These anti-fraud measures—so unprecedented in scale—were the result of a concerted governmental effort to curb fraud within the healthcare industry.

The latest weapon in the government's arsenal is a provision in the Patient Protection and Affordable Care Act of 2010 (PPACA) that takes aim at overpayments and significantly increases the organizational risk involved with retaining an overpayment for healthcare services. Section 6402(d) (Reporting and Returning of Overpayments) of PPACA requires a provider to report and return an overpayment to the appropriate Medicaid state agency or Medicare contractor within sixty days of its identification. The provider must also supply, in writing, an explanation for the overpayment. This provision applies to healthcare providers, suppliers, Medicaid managed care organizations, Medicare Advantage organizations, and Prescription Drug Plan sponsors. The retention of an overpayment beyond sixty days, no matter how innocuous, is a violation of the FCA. Thus, the FCA will play an important role in determining the ramifications of retaining an overpayment.

FCA, FERA, and PPACA: The Triumvirate of Healthcare False Claims Liability

FCA

The FCA is the government's primary enforcement mechanism against fraud. The act imposes civil liability on any person who knowingly uses a "false record or statement to get a false or fraudulent claim paid or approved by the Government," or any person who "conspires to defraud the Government by getting a false or fraudulent claim allowed or paid."[3] In addition to policing fraud, the FCA is also a significant source of revenue, thanks to its provision for treble damages and penalties ranging from $5,500 - $11,000 per violation. In fact, the Obama Administration touted FCA recoveries as a source that would be central to financing healthcare reform.[4]

To incentivize FCA actions, the law empowers private parties to bring a qui tam action on behalf of the United States. Historically, the qui tam suit was an English common law device that permitted citizens to prosecute a claim on the King's behalf. Like its English predecessor, the modern qui tam plaintiff—a "relator"—shares in the recovery from a successful claim, with the percentage varying based on whether or not the government chooses to intervene in the action.

The Fraud Enforcement and Recovery Act

The FCA has undergone more than one makeover since its enactment back in 1863, including in May 2009 when President Barack Obama signed the Fraud Enforcement and Recovery Act[5] (FERA) into law. The FERA amended the FCA's provision dealing with reverse false claims, which occur when a party attempts to avoid an obligation to pay the government. Under the amendment, neither a qui tam plaintiff nor the government has to show that the provider used a false statement to conceal this obligation. Rather, in order to be brought within the ambit of the FCA, it must only be shown that the claimant knowingly concealed the obligation. This occurs when the person has actual knowledge of the obligation or acts in "deliberate ignorance" or in "reckless

disregard" for the truth. The FERA also significantly expanded liability under the FCA by prohibiting a provider from "knowingly and improperly avoid[ing] or decreas[ing] an obligation to pay or transmit money or property to the government." The net effect of the FERA amendments was to make a claimant liable for the *retention* of an overpayment, and no longer requiring an affirmative act in its furtherance.

PPACA

The latest amendment to the FCA came with the passage of PPACA, which continued the trend of increasing healthcare providers' exposure to liability under the FCA. Section 6402(d) of PPACA expanded the scope of the FCA yet again to explicitly include Medicare and Medicaid overpayments as "obligations" within the meaning of the FCA. The drafting of the legislation left much to be desired, as many key aspects are undefined.

Ambiguities of "Reporting and Returning" Legislation

As a result of PPACA Section 6402(d), a healthcare provider that, for whatever reason, receives an overpayment may now be in jeopardy of violating the FCA. What could have been a simple billing error now has the potential to expose the provider to substantial monetary penalties. Turning to the substance of the law may leave the provider with material questions about overpayments and their return. Recently, though, CMS issued a proposed rule on overpayments in the February 16, 2012, *Federal Register*.[6] While the proposed rule fills in some gaps, ambiguities remain.

What Is an Overpayment?

The proposed rule defines an overpayment as ". . . any funds a person receives or retains under title XVIII of the [Social Security] Act to which the person, after applicable reconciliation, is not entitled under such title."[7] (The "applicable reconciliation" reference pertains to a cost-reporting provider and the rule clarifies that the only overpayments that may be delayed until the cost report is due are ones reconciled by the cost report.) The preamble in the regulation provides a number of examples of overpayments, and interestingly, they are identical to ones previously proposed in 1998 when the Centers for Medicare & Medicaid Services (CMS) attempted to amend Medicare regulations governing liability for overpayments.[8] They include:

- Payments made by Medicare for non-covered services;
- Payments in excess of the allowable amount for an identified covered service;
- Errors and non-reimbursable expenditures in cost reports;
- Duplicate payments; and
- Medicare payment when another entity had the primary responsibility for the payment.

In spite of these examples, there is still ambiguity regarding what deems a provider as being "not entitled" to a payment. Neither the 1998 rule, nor the current proposed rule, have attempted to flesh out this term.

Identification of an Overpayment

Under PPACA, an overpayment must be reported and returned within sixty days from the date on which the overpayment was "identified," or the date any corresponding cost report is due. The clarification of when an overpayment has been identified is important, as it is the triggering mechanism for the sixty-day timetable for reporting and returning the funds. It may be proffered that a spectrum of certainty exists regarding overpayments, ranging from a suspicion that one has occurred on one end, over to unmistakable knowledge that one has occurred on the other end. Providers and compliance officers must know at what point on the spectrum the law's teeth take hold and the clock starts ticking.

The proposed rule states that a payment has been identified if a person "has actual knowledge of the existence of the overpayment or acts in reckless disregard or deliberate ignorance of the overpayment." This definition is meant to incentivize providers to exercise reasonable diligence in determining whether an overpayment has occurred. Without it, CMS reasons, some may avoid activities such as self-audits and compliance checks.

In the preamble of the proposed rule, CMS provided some examples of when an overpayment has been "identified" for purposes of the law:

- A provider reviews billing or payment records and learns that it incorrectly coded certain services, resulting in increased reimbursement.

- A provider learns that a patient death occurred prior to the service date on a claim that has been submitted for payment.
- A provider learns that services were provided by an unlicensed or excluded individual on its behalf.
- A provider performs an internal audit and discovers that overpayments exist.
- A provider is informed by a government agency of a potential overpayment, and the provider fails to make a reasonable inquiry.
- A provider experiences a significant increase in Medicare revenue for no apparent reason.

The proposed definition, along with the examples of overpayment identification, indicate an intent by the U.S. Department of Health and Human Services (HHS) to affix liability at a relatively early point on the spectrum described above. A provider who fails to conduct a reasonable inquiry after it learns of a potential overpayment, or who fails to conduct that inquiry in a timely manner, may have knowingly retained an overpayment. If adopted in its current form, the CMS rule will put to rest any doubt that some indicia of an overpayment will start the sixty-day clock. Nevertheless, certain situations could lead to a tit-for-tat argument between the government and providers about when the actual identification of the overpayment occurred. Also, the proposed rule sidesteps the fact that sixty days may not be a sufficient period of time for many providers to conduct a "reasonable inquiry" and determine the actual amount of the overpayment. This element is likely to be the subject of many comments on the proposed rule.

Erosion of Substantive Defenses

As if the ambiguities in the overpayment rules were not enough, a provider's ability to defend itself against an alleged FCA violation has taken some hits. There are two common defenses to an FCA allegation, neither of which has emerged unscathed from the trend of increased liability. By all appearances, recent court decisions and PPACA provisions have eroded the effectiveness of FCA defenses, making it more difficult for a healthcare provider to defend against a claim of retention of an overpayment.

9(b) Motion

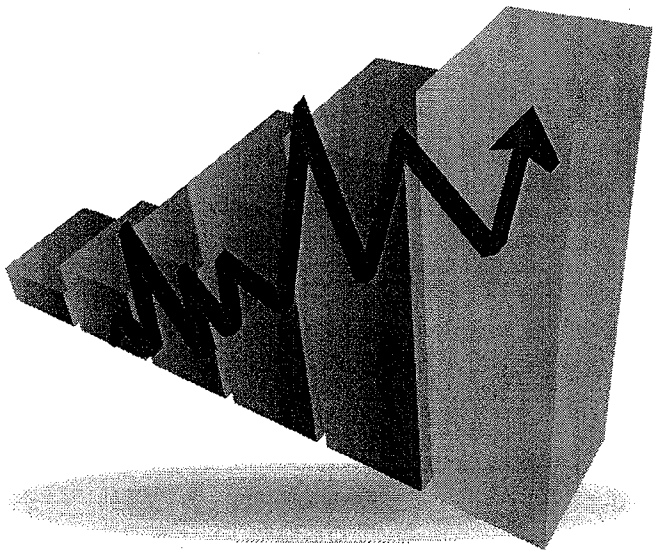
Historically, a viable defense to an alleged FCA violation is a motion to dismiss for failure to plead fraud with particularity under the Federal Rules of Civil Procedure Rule 9(b).[9] To satisfy the Rule 9(b) standard, a plaintiff's pleading must specify the "time, place, and substance of the defendant's alleged conduct."[10] These details may be difficult to come by for a whistleblower in the healthcare setting, where evidence such as "observations and conversations" alone have been insufficient.[11] Instead, the pleading has been required to set forth, at the very least, the "who, what, when, where, and how of the alleged fraud."[12] Some circuit courts have gone as far as to require a qui tam relator to provide details such as the dates of the claims, content of the forms or bills, identification numbers, amount of money involved, the particular goods or services for which the government was billed, and the individuals involved.[13] Motions to dismiss FCA claims have successfully used Rule 9(b) on several occasions.[14]

However, there is an increasing trend in recent circuit court decisions to interpret the Rule 9(b) particularity requirement differently in FCA cases.[15] Under a relaxed standard, the qui tam plaintiff must only allege the details of a fraudulent *scheme*, rather than the details of the claims themselves.[16] For example, in *U.S. ex rel. Grubbs v. Kanneganti*, a doctor brought a qui tam action against his physician colleagues and hospital employer. He alleged the physicians billed Medicare and Medicaid for face-to-face visits when they actually only met with nursing staff. The Fifth Circuit held that the plaintiff did not necessarily need the exact dollar amounts, billing numbers, or dates to prove by a preponderance that fraudulent bills were actually submitted for payment.[17]

This lowering of the pleading bar may allow future whistleblowers the luxury of relying on generalities regarding an alleged fraudulent practice and eliminate the need for plaintiffs to have access to the details of the overpayment.

Public Disclosure Bar

A healthcare provider facing a charge of impermissibly retaining an overpayment has a second defense available. A qui tam action brought under the PPACA's overpayment provision could be susceptible to a proper 12(b)(6) motion via the "public disclosure bar" of the FCA.[18] Congress added the public disclosure bar to the FCA in 1986 as a way of weeding out "parasitic lawsuits"—ones based on information that had been previously disclosed in public, either in the news media or in a governmental investiga-

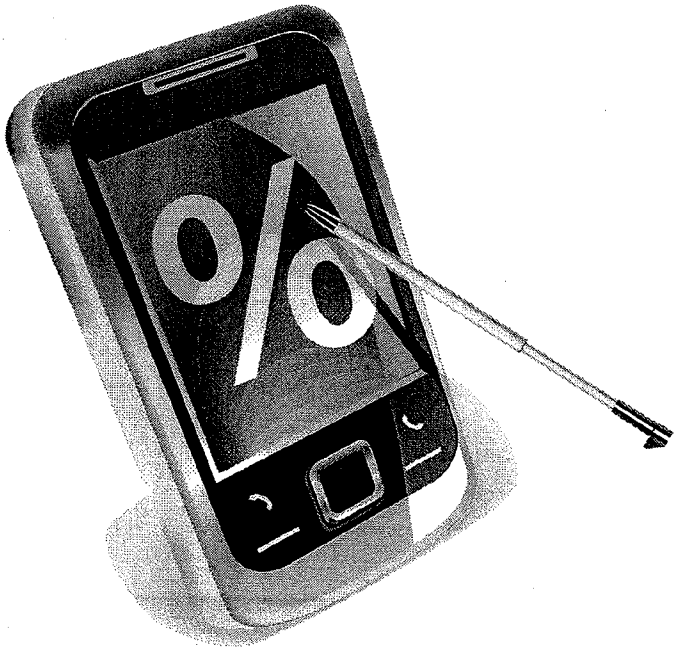


tion or hearing. The rule operated to ensure whistleblower suits under the FCA were based on fresh information regarding allegations of previously unknown fraud.

PPACA, however, has dealt several blows to the public disclosure defense. First, PPACA explicitly limited "public disclosures" to federal proceedings and reports, effectively nullifying a 2010 Supreme Court decision.[19] That case—*Graham County Soil and Water Conservation Dist. v. U.S. ex rel. Wilson*—expanded the scope of the public disclosure bar to include state and local proceedings and reports. But PPACA has narrowed the scope to allegations disclosed only in the news media or a "congressional, Government Accountability Office, or other Federal report, hearing, audit, or investigation." This rule not only excludes allegations disclosed in a state proceeding, but impliedly excludes disclosures that occur during private litigation as well. Thus, the public disclosure bar is only implicated if a disclosure occurs in a federal proceeding or makes its way into the media.

Secondly, even if a disclosure has occurred in a federal proceeding, PPACA gives DOJ the opportunity to oppose a defendant's motion to dismiss. The language of the statute requires the court to dismiss the action when a disclosure in a federal proceeding has occurred, "unless opposed by the Government." This gives DOJ a crucial role to play in allowing a qui tam suit to proceed where it otherwise would have been dismissed because of a public disclosure.

Lastly, by altering the exception to the public disclosure bar, PPACA has made it markedly easier for a private party to bring a qui tam suit. Prior to the Act, those relators who were an "original source" of the information could proceed with their claim, despite a public disclosure. However, the relator must have possessed "direct and independent" knowledge of the claim. PPACA amended this by eliminating the "direct and independent" knowledge test and replacing it with a two-pronged alternative. Either: (1) the individual voluntarily disclosed the information to the government prior to the public disclosure; or (2) the individual possess information that materially adds to the publicly disclosed allegations.



It is unclear at this point what type of information would "materially add" to the public allegations, or even how much information is required to render it material. What is known is that the public disclosure bar no longer ensures that qui tam plaintiffs are true whistleblowers. The "original source" amendment casts a wide net in terms of who may qualify as a whistleblower and opens the door for those without firsthand knowledge of an overpayment to bring a qui tam action. This combined with the less-stringent pleading standards show that the landscape for qui tam plaintiffs in healthcare fraud suits is becoming demonstrably more favorable.

Raising the Stakes: Implications for Healthcare Providers

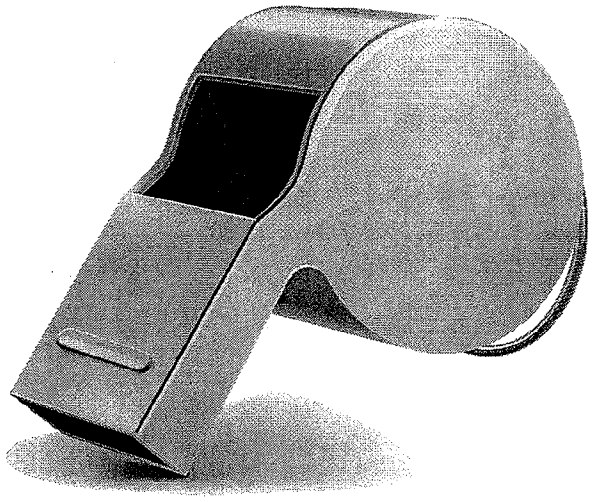
The possible implications of Section 6402(d)'s "Reporting and Returning of Overpayments" extend beyond fines and penalties under the FCA.

Medicare and Medicaid Exclusions Under the "Responsible Corporate Officer" Doctrine

Under the responsible corporate officer doctrine, an officer may be liable for civil and criminal penalties where the officer participates in corporate wrongdoing, knowingly approves of wrongful conduct, or was in a position to prevent the wrongdoing, but failed to do so. In March 2011, the HHS Inspector General testified before Congress regarding the efforts of HHS to combat waste, fraud, and abuse in Medicare and Medicaid. The Inspector General testified that the Office of Inspector General (OIG) is targeting enforcement at individual leaders within the healthcare industry and is increasingly seeking to punish those in positions of responsibility within the organizations.

Punishment for Medicare or Medicaid fraud usually involves excluding the individual from the programs for three years. However, HHS recently imposed a twelve-year exclusion on three pharmaceutical executives charged with misdemeanor drug misbranding. The unusually severe penalties were upheld in federal district court and will likely end the pharmaceutical careers of the three executives.[20]

The severity of recent penalties under the responsible corporate officer doctrine, coupled with the Inspector General's expressed intent to punish corporate fraud on the individual officer level, is evidence that reducing fraud and abuse is a priority of the OIG. One need look no further than the "Reporting and Returning of



Overpayments" provision of PPACA to recognize that dealing with overpayments is a centerpiece of that effort. This will require heightened vigilance on the part of healthcare executives. The failure to systematically, promptly, and consistently identify overpayments could result in personal, career-ending consequences, in addition to liabilities under FCA.

Whistleblower Actions

The upshot of the more-lenient standard for Rule 9(b) motions and the relaxed interpretation of the public disclosure bar is the possibility for an increase in whistleblower actions. Where a whistleblower might once have been precluded from bringing a qui tam action for lack of knowledge of the particulars of the overpayment, or by a previous disclosure in a state proceeding or private litigation, the whistleblower now faces few obstacles. And during an economic downturn, the lure of a share in the recovery might prove quite tempting to pursue.

Conclusion

PPACA Section 6402(d) is a small provision, but it will almost certainly have important and far-reaching implications for the healthcare industry. Like many laws, it features ambiguities that may lead to misinterpretation and confusion. Defenses to allegations of FCA violations have been eroded, and exposure for corporate officers and for providers to whistleblower actions have increased. In addition, in the proposed overpayment rule, CMS is now pushing for a ten-year look-back period by amending the current regulations that typically result in a four-year period. Therefore, healthcare providers would do well to remain vigilant for overpayments, know the rules, and timely act to mitigate the associated risks. Otherwise, unless some FCA cases involving overpayments proceed to trial and the courts provide some interpretations that afford relief for defendants, it appears the proverbial deck now is somewhat stacked against providers.

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1 Press Release, U.S. Department of Justice, Justice Department Recovers $3 Billion in False Claims Act Cases in Fiscal Year 2011 (Dec. 19, 2011).

2 Kelly Kennedy, *Medicare fraud sting results in 91 arrests nationwide*, USA Today, Sept. 7, 2011.

3 31 U.S.C. §3729-3733.

4 President Barack Obama, Remarks to a Joint Session of Congress (Sept. 9, 2009) ("We've estimated that most of this [health care reform] plan can be paid for by finding savings within the existing health care system, a system that is currently full of waste and abuse").

5 Fraud Enforcement and Recovery Act, 31 U.S.C. § 3729 (2009).

6 77 Fed. Reg. 9179 (Feb. 16, 2012).

7 The proposed definition only references the Medicare program because CMS has indicated in the preamble to the proposed rule that, at this time, it is proposing to implement the overpayment requirements only as they relate to Medicare Part A and Part B providers and suppliers. CMS indicates that "other stakeholders" will be addressed at a later date.

8 Medicare Program; "Without Fault" and Waiver of Recovery from an Individual as it Applies to Medicare Overpayment Liability, 63 Fed. Reg. 14506, 14517 (March 25, 1998).

9 Fed. R. Civ. P. 9(b).

10 *U.S. ex rel. LaCorte v. SmithKline Beecham Clinical Laboratories, Inc.*, 149 F. 3d 227, 234 (3d Cir. 1998).

11 *Gublo v. NocaCare, Inc.*, 62 F. Supp. 2d 347 (D. Mass 1999).

12 *Id.*

13 *U.S. ex rel. Karvelas v. Melrose-Wakefield Hosp.*, 360 F. 3d 220 (1st Cir. 2004).

14 *See U.S. ex rel. LaCorte v. SmithKline Beecham Clinical Laboratories, Inc.*, 2000 WL 17838 (E.D. La. 2000); *U.S. ex rel. Cox v. Iowa Health System*, 29 F. Supp. 2d 1022 (S.D. Iowa 1998); *U.S. ex rel. Butler v. Magellan Health Services, Inc.*, 74 F. Supp. 2d 1201 (M.D. Fla. 1999).

15 *See U.S. ex rel. Duxbury v. Ortho*, 579 F. 3d 13; *also see U.S. ex rel. Grubbs v. Kanneganti*, 565 F. 3d 180.

16 *U.S. ex rel. Grubbs v. Kanneganti*, 565 F. 3d 180, 190 (5th Cir. 2009) (Higginbotham, J.) ("To require these details [time, place, contents, identity] at pleading is one small step shy of requiring production of actual documentation with the complaint, a level of proof not demanded to win at trial and significantly more than any federal pleading rule contemplates.").

17 *Id.* at 190.

18 31 U.S.C. § 3730(e)(4)(2010).

19 *Graham County Soil and Water Conservation Dist. v. U.S. ex rel. Wilson*, 130 S. Ct. 1396 (2010), *abrogating United States ex rel. Dunleavy v. County of Delaware*, 123 F. 3d 734 (3rd. Cir. 1997)

20 *Friedman v. Sebeluis*, 755 F. Supp. 2d 98 (D.D.C. 2010).