

**2011 HEALTHCARE FINANCIAL MANAGEMENT ASSN.
NORTHERN CALIFORNIA SPRING CONFERENCE**

Fraud and Abuse After Health Care Reform: A Primer

Presented by:

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Goals for Today's Presentation

- Review legal authorities relating to repayments and disclosures under Medicare and Medicaid, including changes made by the Patient Protection and Affordable Care Act ("PPACA")
- Discuss how Federal False Claims Act ("FCA") liability was heightened by the mandatory repayment provisions in PPACA
- Present practical steps to take in response to the changes made by PPACA and the changes made to the FCA by the Fraud Enforcement and Recovery Act of 2009 ("FERA")

Goals for Today's Presentation

- Review how far back for overpayments you go/how far back the government can go; what is the effect of administrative finality
- Discuss to which agency should you report and what should you say, including the effect of PPACA's Medicare Self-Referral Disclosure Protocol
- Discuss special repayment and disclosure issues that arise from RAC/MIC Audits

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Practical Responses –Notice of Possible Overpayment

- Where notices of possible overpayments come from:
 - Government demand
 - Other outside notice
 - Inside notice – compliance plan hot-line, internal audit exit interview
- Once receiving notice of a possible overpayment:
 - Must you follow-up?
 - If you must follow-up, what is the scope and timing of the follow-up?

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Practical Responses –Notice of Possible Overpayment

- Follow-up on a notice of a possible overpayment can be divided into the following three phases:
 - Investigation
 - Developing the refund/disclosure strategy
 - Implementing the selected strategy

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Practical Responses –Notice of Possible Overpayment

- The Investigation Phase:
 - Obtaining the relevant facts (*e.g.*, interviews, collection of documents)
 - Reviewing substantive law regarding the possible overpayment
 - Do any recovery waivers apply?
 - Post-PPACA – need to move very quickly

For this phase, you need to identify the key people to interview and get your interview team in place

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Practical Responses –Notice of Possible Overpayment

- Developing a Refund/Disclosure Strategy:
 - Complete review of law
 - Assessment of Results of factual investigation
 - Strategy/Development
- For this phase, you need to assemble an experienced, multi-disciplinary team that may include billing/coding consultant, health regulatory lawyers (reimbursement/fraud & abuse), white collar lawyer, corporate lawyer, tax lawyer.
- There are often not clear answers as to best way to proceed, so knowledge and judgment are important.
- Post-PPACA – may need to report/return before the investigation has been completed

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Practical Responses –Notice of Possible Overpayment

Implementation of the Refund/Disclosure Strategy:

- Once you have decided on a strategy, there is still a need for skillful implementation
- The communications with the government can be delicate.
- Need to have representatives with proper “touch.”
- How to best “frame” the issue.
- Who is the best “face” for the organization.
- Benefit of an effective compliance plan.

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Medicare Overview

Other important issues:

- The Medicare Payment Process, including Finality
- How Medicare Overpayments Arise
- Waiver of Overpayment Recoveries
- The Government's Overpayment Recovery Authorities
- The Government's Authority to Impose Interest

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Medicaid Overview

With regard to Medicaid, it is important to know:

- How Medicaid Overpayments Arise
- How Recovery Actions Differ under Medicare and Medicaid
- Medicaid Payment and Third Party Liability Recovery Provisions
- The Medicaid Integrity Program
- Selected Authorities Relating to Refunding Medicaid Overpayments
- Responding to Medicaid Overpayment Demands

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The Federal False Claims Act

- Civil statute providing for damages and penalties for improperly seeking to obtain government funds or avoiding an established duty to pay the government
- Liability attaches to, among others, those who present, or who cause another to present, a claim for payment to the U.S.
- Many states have their own FCAs
- Significant changes to the FCA made by FERA

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Reverse False Claims and Overpayment Obligations: Statutory Language

- Old 31 U.S.C. §3729(a)(7)
 - “Any person who... knowingly makes, uses, or caused to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government....”
- New 31 U.S.C. §3729(a)(1)(G)
 - “Any person who... 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...” (emphases added).

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FERA's Changes Concerning Liability For Reverse False Claims

- FERA establishes liability for a person who:
 - “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.” (*emphasis added*)
- OR
- “Knowingly conceals . . . an obligation to pay or transmit money or property to the Government”
- OR
- “**Knowingly and improperly** avoids or decreases an **obligation** to pay or transmit money or property to the Government.” (*emphasis added*)

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Key Defined and Undefined Terms

- “Material” 31 U.S.C. §3729(b)(4) -- “having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property.”
- “Obligation” 31 U.S.C. §3729(b)(3) - “an **established duty**, whether or not fixed, **arising from** an express or implied contractual, grantor-grantee, or licensor-licensee relationship, from a fee-based or similar relationship, from statute or regulation, or from the retention of any **overpayment**...” (emphases added).

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Key Defined and Undefined Terms

- Undefined Terms:

- “Improperly”

- ❖ The Committee Report states: “The Committee does not intend this language to create liability for a simple retention of an overpayment that is permitted by a statutory or regulatory process for reconciliation provided that the receipt of the overpayment is not based on any willful act of a recipient to increase the payments from the Government when the recipient is not entitled to such Government money or property.”

- “Established duty... arising from”

- “Overpayment”

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What *Is* An “Obligation” / “Established Duty” Under New (a)(1)(G)?(22)

- Consistent with previous jurisprudence?
- “Obligation” now defined by statute as an “established duty... arising from” any one of eight prescribed sources:
 - Express contractual relationship
 - Implied contractual relationship
 - Grantor-grantee relationship
 - Licensor-licensee relationship
 - Fee-based or similar relationship
 - Statute
 - Regulation
 - Retention of overpayment

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Potential Sources of “Established Duty” – Contractual Relationships

- Contractual Relationships
 - Enrollment agreement (CMS Form 855)
 - EDI agreement, §5? (CMS Form 8275)
 - Medicare Participating Physician or Supplier Agreement, §1?
 - Corporate Integrity Agreement
 - Certification of Compliance Agreement

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Potential Sources of “Established Duty” – Statutes

*42 U.S.C. §1320a-7k(d) - Reporting and Returning of
Overpayments (added by PPACA)*

“(1)In general.— If a person has received an overpayment, the person shall (A) report and return the overpayment to the Secretary, the State, an intermediary, a carrier, or a contractor, as appropriate, at the correct address; and (B) notify the Secretary, State, intermediary, carrier, or contractor to whom the overpayment was returned in writing of the reason for the overpayment.”

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Potential Sources of “Established Duty” – Statutes

42 U.S.C. §1320a-7k(d) – cont’d

“(2)Deadline for reporting and returning overpayments.— An overpayment must be reported and returned under paragraph (1) by the later of (A) the date which is 60 days after the date on which the overpayment was identified; or (B) the date any corresponding cost report is due, if applicable.”

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Potential Sources of “Established Duty” – Statutes

42 U.S.C. §1320a-7k(d) – cont’d

“(3)Enforcement.— Any overpayment retained by a person after the deadline for reporting and returning the overpayment under paragraph (2) is an obligation (as defined in section 3729(b)(3) of title 31, United States Code) for purposes of section 3729 of such title.”

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Potential Sources of “Established Duty” – Statutes

42 U.S.C. §1320a-7k(d) – cont’d

“(4) Definitions.— In this subsection:

(A) Knowing and knowingly.— The terms knowing and knowingly have the meaning given those terms in section 3729(b) of title 31, United States Code.

(B) Overpayment.— The term "overpayment" means any funds that a person receives or retains under title XVIII or XIX to which the person, after applicable reconciliation, is not entitled under such title.”

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Potential Sources of “Established Duty” – Statutes

42 U.S.C. §1320a-7k(d) – cont’d

“(C) Person. (i) In general.— The term person means a provider of services, supplier, medicaid managed care organization (as defined in section 1903(m)(1)(A)), Medicare Advantage organization (as defined in section 1859(a)(1)), or PDP sponsor (as defined in section 1860D-41(a)(13)). (ii) Exclusion.— Such term does not include a beneficiary.”

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Potential Sources of “Established Duty” – Statutes

42 U.S.C. §1395cc(a)(1)(C)

Requirement for participating providers to have an agreement with CMS “to make adequate provision for return (or other disposition, in accordance with regulations) of any moneys incorrectly collected from such individual or other person.”

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Potential Sources of “Established Duty” – Statutes

42 U.S.C. §1395gg

Where an overpayment has been made and cannot be recovered from a provider, this statute states that “*proper adjustments shall be made . . . by decreasing subsequent payments*” on behalf of the beneficiary.

Provider “*shall, in the absence of evidence to the contrary, be deemed to be without fault if the Secretary's determination that more than such correct amount was paid was made subsequent to the third year following the year in which notice was sent.*”

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Potential Sources of “Established Duty” – Statutes

42 U.S.C. §1395y(b)(2)(B)(ii)

“A primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this title with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service.”

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Potential Sources of “Established Duty” – Statutes

42 U.S.C. §1395u(l)(1)(A)

A nonparticipating physician who does not accept assignment on a claim that is found to be medically unnecessary must, in the absence of a valid Advanced Beneficiary Notice, refund any payment collected from a beneficiary “within 30 days after the date the physician receives a denial notice.”

“If a physician knowingly and willfully fails to make refunds in violation of paragraph (1)(A), the Secretary may apply sanctions against such physician in accordance with subsection (j) (2)” (which include CMPs and exclusion from the Medicare program).

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Potential Sources of “Established Duty” – Statutes

42 U.S.C. §1320a-7b(a)(3)

Criminal liability against whoever “having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment, or (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized. . . .”

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Potential Sources of “Established Duty” -- Regulations

42 C.F.R. §489.41

*“(a) Prompt refund to the beneficiary or other person is the preferred method of handling incorrect collections.
(b) If the provider cannot refund within 60 days from the date of the notice of incorrect collection, it must set aside an amount, equal to the amount incorrectly collected, in a separate account identified as to the individual to whom the payment is due. This amount incorrectly collected must be carried on the provider's records in this manner until final disposition is made in accordance with the applicable State law.”*

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Potential Sources of “Established Duty” -- Regulations

42 C.F.R. §411.22

“ (a) A primary payer, and an entity that receives payment from a primary payer, must reimburse CMS for any payment if it is demonstrated that the primary payer has or had a responsibility to make payment. . . .”

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Potential Sources of “Established Duty” -- Regulations

42 C.F.R. §411.24(h)

“If the beneficiary or other party receives a primary payment, the beneficiary or other party must reimburse Medicare within 60 days.”

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Potential Sources of “Established Duty”
– Medicaid Statute

*In addition to 42 U.S.C. §1320a-7k(d),
42 U.S.C. §1396b(d)(2)(A)*

*“The Secretary [of Health and Human Services] shall ... pay to the State, in such installments as he may determine, the amount so estimated [under the previous paragraph], **reduced or increased to the extent of any overpayment or underpayment** which the Secretary determines was made under this section to such State for any prior quarter and with respect to which adjustment has not already been made under this subsection.”*

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Potential Sources of “Established Duty”
– Medicaid Statute

42 U.S.C. §1396b(d)(2)(B)

“Expenditures for which payments were made to the State under subsection (a) of this section shall be treated as an overpayment to the extent that the State or local agency administering such plan has been reimbursed for such expenditures by a third party pursuant to the provisions of its plan in compliance with section 1396a(a)(25) of this title.”

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Potential Sources of “Established Duty”
– Medicaid Statute

42 U.S.C. §1396b(d)(2)(C) – Changed by PPACA

*“For purposes of this subsection, when an overpayment is discovered, which was made by a State to a person or other entity, **the State shall have a period of 1 year in which to recover or attempt to recover such overpayment before adjustment is made in the Federal payment to such State on account of such overpayment. Except as otherwise provided in subparagraph (D), the adjustment in the Federal payment shall be made at the end of the 1-year period, whether or not recovery was made.**”*

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Potential Sources of “Established Duty”
– Medicaid Statute

42 U.S.C. §1396a(a)(25)(A)

*“[T]he State or local agency administering such plan [i.e., the Medicaid State Plan] will **take all reasonable measures to ascertain the legal liability of third parties** (including health insurers, group health plans (as defined in section 607(1) of the Employee Retirement Security Act of 1974 [29 U.S.C. 1167(1)]), service benefit plans, and health maintenance organizations) to pay for care and services available under the plan. . . .”*

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Potential Sources of “Established Duty” – Medicaid Statute

42 U.S.C. §1396a(a)(25)(B)

“[I]n any case where such a legal liability is found to exist after medical assistance has been made available on behalf of the individual and where the amount of reimbursement the State can reasonably expect to recover exceeds the costs of such recovery, the State or local agency will seek reimbursement for such assistance to the extent of such legal liability; . . .”

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Additional Enforcement Tool

CMP Added By PPACA

- Section 6402(d)(2) of PPACA amends the federal CMP statute
- New 42 U.S.C. §1320a-7a(a)(10) exposes CMP liability to any person *“that knows of an overpayment (as defined in paragraph (4) of [42 U.S.C. §1320a-7k(d)]) and does not report and return the overpayment in accordance with such section.”*
- The CMP for violations of this provision is up to \$10,000 for each item or service, plus an assessment of up to three times the amount claimed for each such item or service.

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Additional Enforcement Tool

CMP Added By PPACA

- *“The Secretary may make a determination in the same proceeding to exclude the person from participation in the Federal health care programs (as defined in [42 U.S.C. §1320a-7b] and to direct the appropriate State agency to exclude the person from participation in any State health care program.” 42 U.S.C. §1320a-7a(a).*

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Important Questions Post-PPACA

- When will an overpayment deemed to be “identified”?
- What is the meaning of “after applicable reconciliation”?
- What is the effect of the mandatory repayment provisions on appeal rights and waiver of liability?
- Is a report and refund a public disclosure for FCA purposes?
- To what extent is administrative finality available as a defense?
- Can overpayments be corrected through adjustment bills, in lieu of reporting/returning?

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Important Questions Post-PPACA

Overpayment Refund Hypothetical

A provider submits a Medicare claim that is properly processed and paid. After receiving payment, the provider determines that the claim, as submitted, was incorrect and, therefore, that it has received an overpayment. The claims-submission period has not yet expired. The provider is considering submitting an adjustment request to correct the payment on the claim.

- Is the claim adjustment process still viable post-PPACA and FERA or must the provider more formally “report and return” the “overpayment”?
- What if the adjustment request is submitted within 60 days of the overpayment being identified?
- What if more than 60 days has passed?

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Potential Sources of “Established Duty” – Regulatory Filing

CMS-838 - for providers to use to identify credit balances (and, therefore, potential overpayments). It must:

- *be submitted 4 times a year, 30 days after the close of each quarter.*
- *include an explanation of the "reason" that it is retaining the credit balance.*
- *be signed by “Officer or Administrator” who certifies that information is “a true, correct, and complete statement prepared from the books and records of the provider in accordance with applicable Federal laws, regulations, and instructions.”*

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Potential Sources of “Established Duty” – Regulatory Filing

- *CMS- 838 states that “[a]nyone who misrepresents, falsifies, conceals, or omits any essential information may be subject to fine, imprisonment, or civil money penalties under applicable Federal laws.”*
- *United States of America ex rel. Richard Jackson v. Yale University School of Medicine*, Civil Action No. 3:97CV02023 (D.C. Conn. Settlement and Release filed September 8, 1998).
- Fresenius Medical Care Holdings Inc (January 2000) – Payment of \$486M to settle criminal and civil claims.
- What is the effect of PPACA report/return requirement on the CMS-838 process?

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Case Study – Stark Law Liability Under FERA

- Effect of FERA amendments on Stark Law violations
- Overpayments made before FERA can be actionable if knowingly retained today
- New *and old* Stark Law violations now actionable in and of themselves and under FCA without falsity/false certification theory

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Stark Law Compliance Prerequisite to Payment

- *42 U.S.C. §1395nn(g)(1) – “Denial of payment. No payment may be made under this subchapter for a designated health service which is provided in violation of subsection (a)(1) of this section.”*
- *42 U.S.C. §1395nn(g)(2) – “If a person collects any amounts that were billed in violation of subsection (a)(1), the person shall be liable to the individual for, and shall refund on a timely basis to the individual, any amounts so collected.”*

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Stark Law Regulations Provide Additional Sanctions for Failure to Refund

- 42 C.F.R. §411.353 - Prohibition on certain referrals by physicians and limitations on billing.

(d) Refunds. An entity that collects payment for a designated health service that was performed pursuant to a prohibited referral must refund all collected amounts on a timely basis, as defined at §1003.101 of this title.
- 42 C.F.R. §1003.102(b) – The OIG may impose a penalty and, where authorized, an assessment against any person (including an insurance company in the case of paragraphs (b)(5) and (b)(6) of this section) whom it determines in accordance with this part—

(9) Has not refunded on a timely basis, as defined in §1003.101 of this part, amounts collected as the result of billing an individual, third party payer or other entity for a designated health service that was provided in accordance with a prohibited referral as described in §411.353 of this title.

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The New Physician Self-Referral Disclosure Protocol

- PPACA directs CMS to establish a protocol for health care providers and suppliers to disclose an actual or potential violation of Stark Laws.
- On September 23, 2010, CMS published the Medicare self-referral disclosure protocol (“SRDP”).
- The protocol is available on CMS’s website at:
http://www.cms.gov/PhysicianSelfReferral/Downloads/6409_SRDP_Protocol.pdf

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New Authority to Compromise Stark Law Liability

- PPACA authorizes HHS to reduce the amount due and owing for all violations under the Stark Law to less than required by statute by considering:
 - Nature and extent of the improper or illegal practice
 - Timeliness of self-disclosure
 - Cooperation in providing additional information related to the disclosure
 - Other factors decided by HHS
- CMS makes clear that it has no obligation to reduce any amounts due and owing.

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Medicare Self-Referral Disclosure Protocol

- A provider of services or supplier may not disclose an actual or potential Stark violation through the SRDP and request an advisory opinion for conduct underlying the same arrangement(s) concurrently.
- Disclosing parties should not disclose the same conduct under both the SDRP and OIG's SDP.
 - When appropriate, CMS may use a disclosing party's submission to prepare a recommendation to OIG and DOJ for resolution of FCA, CMP or other liability
- At the time the disclosing party electronically submits a disclosure under the SRDP (and receives email confirmation of receipt from CMS), the obligation to return any potential overpayment within 60 days will be suspended until a settlement agreement is entered, the disclosing party withdraws from the SRDP or CMS removes the disclosing party from the SRDP.

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Medicare Self-Referral Disclosure Protocol (cont'd)

- The fact that a disclosing party is already subject to government inquiry (including investigations, audits or routine oversight activities) does not automatically preclude a disclosure.
- SRDP cannot be used to obtain a CMS determination as to whether an actual or potential Stark violation occurred (the advisory opinion process should be used for this purpose).
- The disclosing party should make a submission to the SDRP with the intention of resolving its overpayment liability exposure for the conduct identified.

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Medicare Self-Referral Disclosure Protocol (cont'd)

- Disclosing party agrees that no appeal rights attach to claims relating to the conduct disclosed if resolved through a settlement agreement (appeal rights are preserved if the disclosing party withdraws or is removed from the protocol).
- If the disclosing party is denied acceptance into, withdraw from or are removed from the SRDP by CMS, the “reopening” rules apply from the date of the initial disclosure to CMS.
 - A “reopening” is a remedial action taken to change a binding determination or decision that resulted in either an overpayment or underpayment, even though the binding determination or decision may have been correct at the time it was made based on the evidence of record.
- Disclosing party must refrain from submitting claims to Federal health care programs or their contractors while matter is under CMS inquiry (unless it first obtains CMS’s consent).

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Required Information to Submit

1. Description of actual or potential violation, including, among other things:
 - A complete legal analysis of the application of the Stark law to the conduct and any applicable exception and a description of the potential causes of the incident or practice.
 - A statement identifying whether the disclosing party has a history of similar conduct or any prior criminal, civil and regulatory enforcement actions (including payment suspensions) against it.
 - Description of the existence and adequacy of a pre-existing compliance program and measures or actions taken to restructure the arrangement or non-compliant relationship.
2. Financial analysis, including the total amount, itemized by year that is actually or potentially due and owing based on the applicable “look back” period
3. Certification by CEO, CFO or other authorized representative

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Request for Additional Information

- CMS may request additional information (e.g., financial statements, income tax returns). Disclosing party will be given at least 30 days to comply.
- CMS states that there may be documents or other materials that are covered by the work product doctrine but which CMS believes are critical to resolving the disclosure; CMS will work with counsel to gain access to the underlying information without waiving privilege.

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Considerations in Deciding Where to Disclose Stark Law “Overpayments”

Disclosure Options

- To FI/MAC
 - Will require full refund of amount paid on claims submitted on prohibited referrals
- To the OIG – but only if Anti-kickback Statute also implicated
 - Can resolve for multiple of remuneration, rather than revenues
- To DOJ/Local U.S. Attorney’s Office
 - Wide disparity in how will handle, but expect to pay multiples
- To CMS under new self-disclosure protocol

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What About Kickbacks?

- PPACA amends the Anti-kickback Statute to provide that any claim that “result[s] from” an AKS violation is now a false or fraudulent claim under the FCA
 - *“a claim that includes items or services resulting from a violation of [the AKS] constitutes a false or fraudulent claim for purposes [of the FCA]”*
- Where items or services included in a claim “result[] from” an AKS violation, that claim is now a false or fraudulent claim under the FCA, even if there is no accompanying certification of compliance with the laws by the entity submitting the claim

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Do Kickbacks Implicate Overpayment Authorities?

- Is a claim infected by a kickback an “overpayment”?
- What if only one component of inpatient care is infected by a kickback. Is the whole DRG the “overpayment”?
- Does the failure to report/repay claims infected by kickbacks create additional liability under the FCA?

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Other Medicare Overpayment Reporting and Refunding Authorities

- Corporate Integrity Agreement
- Compliance Plans
- Sarbanes-Oxley (publicly traded companies)

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Other Medicare Overpayment Recovery Authorities

- Medicare Act
 - 42 U.S.C. §1395ff(b)(1)(G) (reopening)
- Federal Claims Collection Act
 - 31 U.S.C. §3711 *et seq.*
 - 42 C.F.R. §405.376(a)
- Debt Collection Improvement Act of 1996
 - 31 U.S.C. §3720C
- False Claims Act
 - 31 U.S.C. §3729 *et seq.*

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Other Medicare Overpayment Recovery Authorities (*Cont'd*)

- Administrative Offset/Reopening – Use of Recovery Contractors
- Subrogated vs. Direct right of action
- Common law self-help
- Equitable Theories - unjust enrichment, payment by mistake of fact, common law fraud, or misrepresentation
- Department of Treasury Offset and Cross-Servicing Programs
- State law – unfair business practices

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Other Medicare Overpayment Recovery Authorities (*Cont'd*)

Statutes of Limitations

- 6 years under 28 §2415
- When does this start running?
- What if no timely notice of overpayment?
- Elements of Cause of Action vs. Right to Sue – Is there, in fact, a recoverable overpayment?

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Other Medicare Overpayment Recovery Authorities (*Cont'd*)

Time Limit for Administrative Offset by DOT

- Debts referred to the Department of Treasury (“DOT”) are subject to recovery through offset without any time limit. 31 U.S.C. §3716(e)(1), as amended by §14219 of the Food, Conservation, and Energy Act of 2008.
- This was explicitly made applicable to Medicare by Section 189 of the Medicare Improvement for Patients and Providers Act of 2008 (“MIPPA”), Pub. L. 110-275 (July 15, 2008).

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Other Medicare Overpayment Recovery Authorities (*Cont'd*)

- 42 U.S.C. §1395ddd(f)(2) limits CMS’s Recovery rights.
- Final Rule published at 74 Fed. Reg. 47,458 (September 16, 2009).
- Interest will continue to accrue during this period of suspension of collection activities. *Id.*; *see also* Transmittal 314 to CMS One-Time Notification Manual (February 1, 2008).

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Other Medicare Overpayment Recovery Authorities (*Cont'd*)

- Practical Considerations
 - Regardless of whether recoupment begins, interest accrues.
 - The recoupment prohibition rules do not apply to all claims. Be sure to check the MFMM.
 - Special rules apply for determining interest due to a provider from reversal of a denial at the ALJ or subsequent levels.
 - The timing of the filing of an appeal of an overpayment determination will affect recoupment.

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Medicaid v. Medicare Recovery Actions

- Medicare - Federal program – focus on recovery of Medicare overpayments from providers.
- Medicaid – Federal/State program – Federal focus on recovering from the State which, in turn, is expected to recover from the provider. *See* “Review of Medicaid Credit Balances at Baystate Franklin Med. Ctr. for the Period Ending June 30, 2006” (Report Number A-01-07-00002) (July 11, 2007) (reviewing federal and state roles in recovering Medicaid provider overpayments).

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Medicaid vs. Medicare

- Mandatory Assignment and Cooperation
- “Payer of Last Resort”
- “Cost Avoidance”
- “Pay and Recover Later”
- 42 U.S.C. §1395vv authorizes CMS to withhold Medicare payments to recover Medicaid overpayments
- 42 U.S.C. §1396m authorizes CMS to withhold Medicaid payments to recover Medicare overpayments

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Medicaid Integrity Program

- Enacted in the Deficit Reduction Act of 2005
- Includes “identification of overpayments”
- Special overpayment contractor to assist “in developing approaches to data mining”

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Responding to Medicaid Overpayment Recovery Demands

1. Did the State follow the TPL requirements?
2. Are the claims administratively “final” and, therefore, no longer subject to governmental recovery actions?
3. Can the provider seek a waiver of recovery directly or on behalf of a patient?
4. Is there, in fact, an overpayment?
5. Has the amount of the overpayment been calculated properly?
6. Did the State meet all applicable Federal procedural requirements?

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The Changing Environment

1. Expanded Use of Contractors to Identify and Pursue Overpayments (Medicare RACs, Medicaid Integrity Contractors (“MICs”), Zone Program Integrity Contractors (“ZPICs”)). Because historical “pay and chase” approach has been slow and costly, other strategies are being considered, including using data mining contractors to identify aberrations in claims. The government gives notice of overpayment refund expectations and uses spot audit and enforcement actions to encourage internal audits, overpayment refunds, and self-disclosures.

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The Changing Environment (Cont'd)

RACs, MICs, ZPICs

What are these entities?

What do they do?

What is the statutory authority for them?

How are they paid?

Discussion of practical issues that arise when dealing with these entities.

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The Changing Environment (Cont'd)

2. Use of Criminal Authority - 18 U.S.C. §1347 (health care fraud) - East Tennessee Heart Consultants (E.D. Tenn.) (Pretrial Diversion Agreement, Federal and State Settlements - January 4, 2007) – Federal, State, Private Use of FCA Authority – *U.S. ex rel. McCaslin v. Harris County Hosp. Dist.*, S.D. Tex., No. H-03-4438, settlement signed 6/4/07 – recovery of MSP and Medicaid TPL overpayments

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New York State Medicaid Self-Disclosure Guidance

Self-Disclosure Guidance issued by the New York State Office of the Medicaid Inspector General (“OMIG”) on March 12, 2009 at http://www.omig.state.ny.us/data/images/stories/self_disclosure/omig_provider_self_disclosure_guidance.pdf

OMIG has developed this approach to encourage and offer incentives for providers to investigate and report matters that involve possible fraud, waste, abuse or inappropriate payment of funds – whether intentional or unintentional – under the state’s Medicaid program.

Guidance at 1.

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New York State Medicaid Self-Disclosure Guidance

- Incentives for disclosure include:

- Forgiveness or reduction of interest payments (for up to two years)
- Extended repayment terms
- Waiver of penalties and/or sanctions
- Timely resolution of the overpayment
- Recognition of the effectiveness of the provider’s compliance and a decrease in the likelihood of imposition of an OMIT Corporate Integrity Program
- Possible preclusion of subsequently filed New York State False Claims Act qui tam actions based on the disclosed matters.

Guidance at 2.

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New York State Medicaid Self-Disclosure Guidance

- Guidance Also Addresses
 - When to disclose (pages 2-3)
 - What issues are appropriate for disclosure (page 3)
 - The disclosure process (pages 3-4)
 - Restitution
 - Timing of resolution

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New York State Medicaid Self-Disclosure Guidance

- OMIG Has Developed a Self-Disclosure Form, also at http://www.omig.state.ny.us/data/images/stories/self_disclosure/omig_provider_self_disclosure_guidance.pdf.
- Form includes the following certification:
I certify that, to the best of my knowledge, the information in this self-report is truthful and is based on a good faith effort to assist the OMIG in it's [sic] inquiry and verification of the disclosed matter.
Form at 4.

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New York State Medicaid Self-Disclosure Guidance

- New York Medicaid recovered \$551 million in 2008 and 2009
- All 50 states recovered \$305 million in 2007

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Medicaid Initiatives in Other States

- Withhold payments on all current claims until all overpayments have been repaid (North Carolina).
- Requirement for Medicaid Agency to “develop regulations addressing the use of extrapolation methodology following an audit of Medicaid providers that clearly defines the difference between actual overpayment of funds to a provider and ministerial omission of clerical billing error that does not result in overpayment to the provider” (Alaska).

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Medicaid Initiatives in Other States

- Use of contractors to audit all providers of a particular service (Louisiana).
- Policy requiring “return” of (known?) credit balances “within 60 days of their receipt” (Massachusetts).

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Medicaid Initiatives in Other States

- When Medicaid repayment or disclosure protocols, such as the New York Medicaid Self-Disclosure Guidance, are established by states, it is important to scrutinize them for federal/state issues.
- This helps assure that repayments/disclosures are properly coordinated at both governmental levels.

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Conclusion

Questions and Answers

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