

# **We Might Have Been Overpaid. What Should We Do?**

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# Goal for the Webinar

To familiarize you with authorities relating to overpayments to help you analyze the benefits and risks of disclosure and decide to whom and how the disclosure should be made.

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# Overview

## Potential Sources of Overpayments under Fee-For-Service Medicare:

- Lack of Medicare eligibility,
- Medicare improperly paid primary,
- Medicare primary but service not statutorily-covered,
- Service statutorily-covered but not medically necessary, or
- Medicare properly primary for medically-necessary, covered service but payment amount was incorrect and excessive.

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# Overview

## Potential Sources of Overpayments under Medicare Advantage:

- Inflated costs in bid submission could result in higher CMS payments
- Unsupported diagnoses reported that result in higher risk scores
- Under-reporting Medicare secondary payer adjustment
- Enrollment errors

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# Three Phases When Overpayment is Suspected

## Phase One:

Conduct an investigation to determine whether there was an actual overpayment

- Before conducting an investigation, consider whether company will self-disclose if overpayment found
- Should not conduct internal investigation unless they intend to correct any detected violations
  - Findings may bear on ability to certify to best knowledge and belief
  - Findings could be used by *qui tam* plaintiff
  - Findings could end up in the Government's hands

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# Phase One: The Investigation

- Gather facts
- Identify applicable law, contractual obligations, etc. relating to possible overpayment
- Perform analysis

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## Phase Two: The Decision – To Disclose or Not

- Assess results of investigation in light of applicable laws, contractual obligations, etc. regarding repayment/disclosure
- Review compliance plan for any self-imposed mandatory disclosure requirement
- Evaluate risks and benefits of disclosure

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# Phase Three: The Disclosure

## Disclosure Issues

- Do we have to disclose?
- What are the risks and benefits?
- Do we have the luxury to investigate before disclosure?
- Who should conduct the investigation?

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# The Art of Disclosure

- Where do I go? - Medicare contractor? CMS? OIG? US Attorney? DOJ?
- Who should make the disclosure? - Should someone with former connections to the government be included?
- Who should be on our team? - What about program expertise?

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# The Big Picture

- No clear overarching Medicare repayment statute or regulation but several specific provisions.
- Administrative finality is elusive in light of expansive government recovery rights
- Strange history of self-disclosure requirements, particularly under Medicare Advantage
- Remember “without fault” and waiver of recovery provisions

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# The Big Picture

- The Changing Environment - Other civil and criminal authorities important
- 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 Health Plan, and Patient Credit Balances

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# Medicare Overpayment Reporting and Refunding Statutory Authorities

*42 U.S.C. § 1395g(a) - “The Secretary shall periodically determine the amount which should be paid under this part to each provider of services . . . with necessary adjustments on account of previously made overpayments or underpayments. . . .”*

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# Medicare Overpayment Reporting and Refunding Statutory Authorities

*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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# Medicare Overpayment Reporting and Refunding Statutory Authorities

*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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# Medicare Overpayment Reporting and Refunding Statutory Authorities

*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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# Medicare Overpayment Reporting and Refunding Statutory Authorities

*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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# Medicare Overpayment Reporting and Refunding Statutory Authorities

*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.”*

CMS’s implementing regulation expansively states, “[a]n entity that collects payment for a designated health service that was performed under a prohibited referral **must refund all collected amounts on a timely basis. . . .**” 42 C.F.R. § 411.353(d) (emphasis added).

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# Medicare Overpayment Reporting and Refunding Statutory Authorities

*42 C.F.R. § 489.20(h) – Duty “if the provider receives payment for the same services from Medicare and another payer that is primary to Medicare, to reimburse Medicare any overpaid amount within 60 days.”*

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# Medicare Overpayment Reporting and Refunding Statutory Authorities

*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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# Medicare Overpayment Reporting and Refunding Statutory Authorities

*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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# Medicare Overpayment Reporting and Refunding Statutory Authorities

*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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# Medicare Overpayment Reporting and Refunding Statutory Authorities

## Proposed Rule:

Reporting and Repayment of Overpayments, 67 Fed. Reg. 3662 (January 25, 2002) - states that “obligation to report and return overpayments is derived from” 42 U.S.C. § 1395gg. Includes an interesting discussion concerning mandatory self-reporting of overpayments. 67 Fed. Reg. at 3662 – 3663. It also references 42 U.S.C. § 1320a-7b(a)(3).

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# Other Medicare Overpayment Reporting and Refunding Statutory Authorities

Medicare Financial Management Manual (“MFMM”):

- Chapter 3, Overpayments
- Chapter 5, Financial Reporting
- Chapter 12, Instructions for Medicare Credit Balance Report Activities

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# Medicare 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

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# Medicare Recovery Authorities

- Administrative Offset/Reopening – Use of Recovery Audit 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 (“DOT”) Offset Program - Debts referred to the DOT are subject to recovery through offset provided that they have not been “outstanding for more than 10 years.” 31 U.S.C. § 3716(e)(1).

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# Medicare Advantage Overpayment Reporting and Refunding Statutory Authorities

In order to evaluate whether there's been an overpayment, need to first understand how MA organizations are paid.

- CMS makes monthly capitation (i.e., per member per month) payments to Medicare Advantage organizations
- MA organizations submit annual bids to CMS of their estimated costs
- Actual CMS payment depends on the relationship between MA organization's bid and benchmark (upper payment limit) established by CMS
- Payments are fully risk adjusted based on member diagnoses

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# Potential Sources of Medicare Advantage Overpayments

- Bid submission
  - Inflated costs submission could result in higher CMS payments
- Risk adjustment data
  - MA organizations are paid more for sicker population. Certain diagnoses drive higher “risk scores,” which result in higher payments.
- Medicare secondary payer adjustment
- Higher than actual reported enrollment

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# Self-Disclosure under Medicare Advantage

- No mandatory self-disclosure obligation under Medicare Advantage – not that CMS hasn't tried!
  - Interim final Medicare+Choice rule included mandatory self-disclosure requirement. Compliance plan had to include an adhered to process for reporting to CMS and/or OIG credible information of law by the M+C organization for a determination as to whether criminal, civil or administrative action may be appropriate. 63 Fed. Reg. 34968 (June 26, 1998).
  - Self-reporting requirement eliminated in final rule because of unfairness of singling out M+C organizations. 65 Fed. Reg. 40170 (June 29, 2000).

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# Self-Disclosure under Medicare Advantage

- CMS tried a second time when promulgating regulations to implement the Medicare Modernization Act's changes that replaced the Medicare+Choice program with Medicare Advantage
- CMS did not finalize the regulation in response to comments that the self-disclosure requirement was "vague and overbroad, with no basis in statute." 70 Fed. Reg. 4588, 4673 (Jan. 28, 2005)

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# Self-Disclosure under Medicare Advantage

- Third time was not the charm - CMS tried again in May 2007 to require self-disclosure, but did not finalize the proposed rule. 72 Fed. Reg. 68700 (Dec. 5, 2007)
- Nevertheless, CMS is “committed to adopting a mandatory self reporting requirement” and solicited comments on:
  - Kinds of offenses for which to require reporting
  - Who is responsible for reporting
  - When to report
  - To whom to report

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# What is in the CMS Arsenal?

- If there is no mandatory self-disclosure under MA, what are CMS's weapons?
  - Heavy reliance on certifications/attestations. "Attestation ... is essential for guaranteeing the accuracy and completeness of data submitted for payment purposes, and to allow [CMS] to pursue penalties under the False Claims Act, where it can be proven that a plan submitted false data." 65 Fed. Reg. 40251 (June 29, 2000).
  - CMS/OIG intermediate sanction authority at 42 C.F.R. § 422.750 et seq.
  - 10 year record retention obligation

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# Certifications under Medicare Advantage

- Bid submission
- Enrollment information relating to CMS payment
  - New enrollments, disenrollments and changes in enrollment status
  - MA organization has reviewed the CMS monthly membership and reply report and has reported any discrepancies
- Risk adjustment data information relating to CMS payment

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# Certifications under Medicare Advantage

- Based on best knowledge, information, and belief as of certification date, information submitted is accurate, complete, and truthful.
- CMS will hold Medicare Advantage organizations responsible for making good faith efforts to certify.

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# Medicare Credit Balances

- *42 U.S.C. § 1395g(a) states that no payments will be made under Part A "to any provider unless it has furnished such information as the Secretary may request in order to determine the amounts due such provider."*
- *42 U.S.C. § 1395l(e), states that payment will not be made under Part B, "unless there has been furnished such information as may be necessary in order to determine the amounts due for such provider or other person."*

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# Medicare Credit Balances

*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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# Medicare Credit Balances

- *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.

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# How Far Back Do You Go?

- Statute of limitation for recovery action
  - 6 years under 28 §2415
  - When does it start running?
- Administrative finality
- What if no timely notice of overpayment? -  
Elements of Cause of Action vs. Right to Sue

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# Other Sources of Repayment Obligations

- 42 USC § 1320a-7b(a)(3) makes it a felony to conceal or fail to disclose an “event” that affects one’s right to receive or retain a Federal health care program payment if it is done with “an intent fraudulently to secure such . . . payment. . .”
- The language of the statute is as follows:
- (a) Whoever---(3) having knowledge of the occurrence of any event affecting (A) his initial or continued right to any . . . benefit or payment [under a Federal health care program (as defined in subsection (f) of this section)], 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, shall be guilty of a felony . . . fined not more than \$25,000 or imprisoned for not more than five years or both”

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# Other Sources of Repayment Obligations

- Corporate Integrity Agreement (“CIA)
- Compliance Plans
- Sarbanes-Oxley (publicly traded companies)
- False Claims Act – 31 U.S.C. §3729 *et seq.*

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# Other Sources of Repayment Obligations

“Reverse false claim” under the civil False Claims Act:

- 31 USC § 3729(a)(7) imposes liability on anyone who “knowingly makes, uses, or causes 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.”

The False Claims Act Corrections Act expands the conspiracy section to apply to “reverse” false claims

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# Disclosure Options – Risks and Benefits

- East Tennessee Heart Consultants case
- Whistleblower case filed by two employees
- East Tennessee has to settle both civil and criminal allegations
- It pays \$1.7 million to resolve the FCA case and agrees to pay an additional \$1.21 million in overpayments that it received from individual patients and insurers
- It enters into a Pretrial Diversion Agreement to resolve the criminal charges against it under 18 USC § 1347 (health care fraud) and 18 USC § 669 (stealing, embezzling or misapplying money or other assets of health care benefit program)

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# Disclosure Options – Risks and Benefits

East Tennessee Is Not Your Average Failure to Refund Case

The whistleblower employees alleged that:

- East Tennessee maintained false records to conceal refunds
- Had a company policy of not making refunds of overpayments
- Accepted payments for patients that it knew it had not treated
- Engaged in this activities for at least six years

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# Disclosure Options – Risks and Benefits

## The East Tennessee Criminal Settlement

- East Tennessee avoided formal criminal charges by entering into an Agreement for Pretrial Diversion
- The Government alleged that East Tennessee's conduct violated 18 USC §§ 1347 and 669
- § 1347 makes it a crime to defraud any health care program
- § 669 makes it a crime to embezzle, steal or misapply property of a health care program

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# Disclosure Options – Risks and Benefits

## The East Tennessee Criminal Settlement (cont'd)

- In the Pretrial Diversion Agreement, the Government alleged that East Tennessee knew that it had received overpayments and that it should have returned them to their rightful owners
- *Importantly, the Government also recited that “on occasion” East Tennessee took action to delay or “obstruct” the return of the funds*

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# Disclosure Options – Risks and Benefits

## Conditions of Pretrial Diversion

- East Tennessee is under the supervision of the US Probation Office
- East Tennessee shall repay all overpayments that it has received since 1995 from all parties, including health care benefit programs and individual patients *with no materiality threshold*
- East Tennessee shall exercise good faith to determine the overpayments and the parties to whom refunds should be made
- East Tennessee will make certain specific payments
- East Tennessee will provide the Probation Office with all documentation requested related to its efforts to make the refunds
- It must make the refunds within 18 months
- The United States agrees not to prosecute East Tennessee if it fulfills these conditions within the 18 month time period

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# Disclosure Options – Risks and Benefits

## CIA's Leave No Doubt

- The East Tennessee CIA requires among other things that it notify the OIG of any “reportable event”
- A reportable event is defined to include an overpayment
- It also includes “any matter that a reasonable person would consider a probable violation of criminal, civil or administrative laws applicable to any Federal health care program”

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# Disclosure Options – Risks and Benefits

## Sulzbach Case

Tenet's former GC is the defendant in a False Claims Act case brought by the Government because it alleges she:

- Failed to disclose payments that Tenet had forfeited the right to receive because of alleged Stark violations
- Failed to disclose violations of the Federal law as required by the CIA

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# Disclosure Options – Risks and Benefits

## Allison Engine Digression

- 31 USC § 3729(a)(2) of the False Claims Act imposes treble damage liability on anyone who knowingly uses a false record or statement “to get a false or fraudulent claim paid or approved by the Government”
- This week the Supreme Court ruled 9 to 0 that to establish liability under 31 USC § 3729(a)(2) it is insufficient to prove that Government funds were used to pay a false claim; rather the whistleblower or the US must prove that the defendant intended that the Government itself pay the claim
- Likewise, it is insufficient under the FCA conspiracy provision to prove that conspirators agreed upon a fraud scheme that caused a private entity to make payments using Government funds; again the proof must show that the conspirators agreed to use false statements that would materially affect the Government’s decisions to pay the false claim

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# How Medicaid Overpayments Arise

- A Medicaid overpayment occurs where the Medicaid payment exceeds what should have been paid.
- ‘Overpayment’ means the amount paid by a Medicaid agency to a provider which is in excess of the amount that is allowable for services furnished under [42 U.S.C. § 1396a] and which is required to be refunded under [42 U.S.C. § 1396b]. See 42 C.F.R. § 433.304

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# Medicaid vs. 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 DRA 2005
- Includes “identification of overpayments”
- \$5M for FY 2006, \$50M for FYs 2007 and 2008, \$75M for FY 2009 and thereafter
- Special overpayment contractor to assist “in developing approaches to data mining”

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# Selected Medicaid Statutory Authority

*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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# Selected Medicaid Statutory Authority

*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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# Selected Medicaid Statutory Authority

*42 U.S.C. § 1396b(d)(2)(C) – “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 60 days 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 60 days, whether or not recovery was made.”*

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# Selected Medicaid Statutory Authority

*42 U.S.C. § 1396a(a)(25)(A) – “that the 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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# Selected Medicaid Statutory Authority

*42 U.S.C. § 1396a(a)(25)(B) – “that in 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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# Selected Medicaid Statutory Authority

*42 C.F.R. § 433.312(a)(1) – “Except as provided in paragraph (b) of this section, the Medicaid agency has 60 days from the date of discovery of an overpayment to a provider to recover or seek to recover the overpayment before the Federal share must be refunded to HCFA.”*

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# Selected Medicaid Statutory Authority

*42 C.F.R. § 433.312(a)(2) – “The agency must refund the Federal share of overpayments at the end of the 60-day period following discovery in accordance with the requirements of this subpart, whether or not the State has recovered the overpayment from the provider, [unless the provider is bankrupt or defunct].”*

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# Questions and Answers

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