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- White Collar -

Lawyers fret health care overpayments

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President Barack Obama speaks about health care in April from the White House.

Last month, the U.S. attorney's office for the Southern District of New York filed a relatively small case against a health care consortium. The suit alleged the group failed to repay nearly $1 million in Medicaid overpayments even though it knew about them for two years.

While the suit is minor from a dollar-value perspective, the case, and the potential for others like it, is causing trepidation among some attorneys who do defense work in the health care sector. They say they're concerned over how prosecutors will interpret certain parts of the Affordable Care Act relating to overpayments.

New regulations in the statute include frightening language for health care providers, according to Matthew D. Umhofer, a former assistant U.S. attorney and partner at Spertus Landes & Umhofer LLP.

"The scariest thing about the Affordable Care Act is a part that hits companies hard for retaining overpayments," Umhofer said in an email. "The government established a 60-day fuse for retaining any overpayment a provider received from the government. This is a terrifying provision for providers, and it's not been tested yet."

This lack of clarity about some of the act's punitive provisions is especially concerning because any overpayment, even the result of an unintentional error, could be subject to the 60-day clock. Penalties for not adhering to the new regulatory requirements are essentially the same as for other False Claims Act violations — forfeiture of the overpaid money and $5,000 to $10,000 in fines per violation, plus treble damages. Depending on the facts of the case, the government could file companion criminal charges, according to Umhofer.

"It's rocked the provider community because it turns any claim overpayment into a false claim," said Mark S. Hardiman, a principal at Nelson Hardiman LLP and another former federal prosecutor. "It essentially creates liability under the False Claims Act for clerical errors. Because of this rule, the distinction between a mistake and a true false claim has largely been conflated now."

The uncertainty is not confined to this single provision of the act. While the health care legislation is technically more than four years old — President Barack Obama signed the bill into law in March 2010 — many of the regulatory rules are still being worked out.

Prosecutions under the False Claims Act are up across the board — in the past five years, the government recouped some $17 billion using the statute, including $3.8 billion in fiscal 2013 alone. By some calculations, false claims prosecutions return more money to the government than any other investment it makes. A study released last fall by the nonprofit Taxpayers Against Fraud Education Fund estimated return-on-investment for false claims cases to be 20 to one.

The Department of Justice has shed little light on how it will enforce the act's new provisions. An agency spokesman, Wyn Hornbuckle, said the department wouldn't elaborate on the statute and how it would be enforced. A spokeswoman for the Centers for Medicare and Medicaid Services, Rachel Maisler, wouldn't discuss the regulatory action other than to provide links to online postings about the act from her office and the Office of Inspector General.

While the government can be slow to step into the fray and identify new forms of fraud, new schemes almost certainly exist that are ripe for prosecution, according to Hardiman, Umhofer and others.

Benjamin N. Gluck, a partner at Bird, Marella, Boxer, Wolpert, Nessim, Drooks, Lincenberg & Rhow PC who has many clients in the health care sector, said the massive increase in regulations stemming from the Affordable Care Act means more opportunities for fraud.

"The ACA does mean there's an increase in regulations, and more regulations equal more opportunities for companies to ignore or skirt them in order to make more money," Gluck said. "For instance, the ACA says that insurance companies must spend at least 80 percent of premiums on the care of subscribers or the insured. If they don't, they have to refund [to subscribers]. But there's plenty of opportunity for mischief there."

This increase in regulatory activity has meant health care providers are turning to attorneys more frequently — and significantly earlier — in order to avoid costly fines and disgorgements.

Instead of doing internal investigations into possible Medicare or Medicaid overpayments as was routine in the past, providers are more likely to bring in an attorney to do the work, according to Hardiman. Now, even when it's a borderline call, companies are bringing in lawyers not only for their expertise, but to show the government that it was proactive in beating the 60-day clock for repayment.

"One of the strategies is to get lawyers involved so the blame can't be laid on the provider," Hardiman said. "It's difficult for the government to prove that it was a strategic move because they would have to get behind the attorney-client privilege and work product rules."

Essentially, Hardiman said, the new regulatory environment has created a new set of rules that everyone is still adapting to.

"I'm generally advising clients that old timelines should basically be thrown in the toilet," he said.

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