Becoming Entangled: The False Claims Act and Medicare Secondary Payer Statute

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It is no secret that, for many years, the Medicare Secondary Payer Statute (MSP) existed as a law on the books only and was rarely enforced.[1] In 2007, Congress enacted new reporting requirements under the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) and gave the MSP new life.[2] These reporting requirements authorize the government to collect the data necessary for MSP enforcement and caused the Centers for Medicare & Medicaid Services (CMS) to refocus its efforts on implementing the MSP.

The renewed attention to the MSP did not go unnoticed by legal counsel practicing in the False Claims Act (FCA) area. The FCA's recent history includes frequent attempts by those bringing such claims to broaden the FCA's scope and equate regulatory violations with false claims.[3] Although over the last decade only a number of FCA actions have involved violations of the MSP against payers and providers, within just the last year two new cases applying the FCA to MSP violations became unsealed.[4] While these cases named liability, no-fault, and workers' compensation insurers, it is no stretch of the imagination to predict that FCA claims against health plans and providers will grow next.

Background on the MSP

The MSP is a coordination-of-benefits (COB) law that requires Medicare to be the secondary payer in certain instances when another party may be responsible for the cost of a beneficiary's health care coverage.[5] When COB occurs, the primary payer will generally pay the bulk of the claim, and the secondary payer will pay any unpaid balance, such as the individual's copayments or deductibles. Accordingly, the secondary payer, typically Medicare, pays much less. Congress enacted the MSP with hopes of it serving as an important money-saver for Medicare.

Specifically, the MSP provides that Medicare will be the secondary payer where a workers' compensation, no-fault, or liability policy (including self-insured plans) has an obligation to cover the medical costs of a beneficiary.[6] With certain exceptions, Medicare also acts as the secondary payer where an employer-sponsored group health plan covers a beneficiary.[7] The exceptions depend on numerous factors, including the employer's size, as well as eligibility for Medicare based on age, disability, or end-stage renal disease, and a beneficiary's work status.[8]

CMS instructs providers to make an initial determination regarding whether a beneficiary may have coverage other than Medicare. To make this determination, CMS directs providers to ask beneficiaries a series of questions pertaining to the cause of an injury and the potential for other coverage.[9] Where the provider finds that a party other than Medicare is the primary payer, the provider is to bill the claim to the primary payer.[10] In instances where the obligation of the primary payer cannot be determined promptly,[11] the MSP allows providers to bill Medicare, and Medicare to make conditional payments for the cost of the beneficiary's health care.[12] In that circumstance, providers are required to code claims to indicate to Medicare that another payer may be responsible.[13]

Once a settlement, judgment, or award demonstrates that a party other than Medicare is responsible for the cost of the beneficiary's services, the other party must repay Medicare for any conditional payments Medicare made within 60 days of such settlement.[14] If a liability insurer pays someone other than Medicare, such as the beneficiary, for the cost of the health care coverage, the party receiving the funds must repay Medicare within 60 days of Medicare's final demand for repayment of the conditional payments (less procurement costs). If the party receiving the funds does not repay Medicare, the primary payer is still liable to Medicare for repayment of Medicare's conditional payments.[15]

The MSP requires that the primary payer notify Medicare if it learns that Medicare made a primary payment for a service the primary payer should have made.[16] Under the MSP, Medicare can recover up to twice the amount of the conditional payments made by Medicare plus interest if the primary payer fails to repay Medicare, and Medicare has to take legal action to recover funds.[17] Medicare also can recover conditional payments made to a provider when the provider fails to file a claim with the primary payer, and Medicare is unable to recover payment from the primary payer.[18] If a provider receives duplicate payments from Medicare and a primary payer, the provider must reimburse Medicare for the overpayment within 60 days of the receipt of duplicate payment.[19]

Background on the FCA

The federal FCA allows private persons with knowledge of fraud against the government to file claims for violations of the FCA on behalf of the government.[20] Such persons are referred to as "relators," and the lawsuits are referred to as "qui tam" actions. The FCA incentivizes relators to bring such actions by allowing relators to share in any amounts recovered.[21] The government must investigate the allegations raised by the relator in the complaint, and at the end of its investigation, the government must decide whether to intervene in the suit.[22] If the government intervenes, it takes over primary responsibility in prosecuting the claims.

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To establish an FCA claim, the prosecuting party, be it the United States or the relator, must prove that: (1) the defendant presented or caused to be presented a false claim to the United States for payment; (2) the claim was in fact false or fraudulent; and (3) the defendant knew of the claim's falsity.[23] When an FCA case is successful, the FCA provides that civil penalties can range from $5,500 to $11,000 per claim plus treble the amount of the government's damages.[24] The FCA entitles the relator to receive between 15-30% of the award in an FCA case, with the variation depending in part on whether the government chose to intervene in the case.[25]

FCA Claims Based on MSP Non-Compliance

Since around the turn of the millennium, relators and the government have been filing FCA suits based on allegations of MSP non-compliance. Relators have named health plans, hospitals, and liability, no-fault, and workers' compensation insurers and self-insured policies as defendants in these suits.

In 2004, the government settled with Highmark Inc. (Highmark) following a relator's FCA action claiming that Highmark failed to notify and repay Medicare for claims in which Highmark should have been the primary payer, but instead paid as the secondary payer.[26] The government previously accused Highmark's predecessor companies of MPS violations resulting in a settlement in 1995.[27] The relator in the FCA case alleged she had been a project manager for Highmark appointed to oversee its implementation of the 1995 settlement.[28] The relator and the government contended that Highmark obtained information that would have allowed it to make accurate determinations pertaining to its primary payer status, but that it failed to incorporate the information into its claims processing system.[29] Thus, the relator and the government alleged that Highmark knew it was erroneously paying claims as the secondary payer.

In responding to a motion to dismiss brought by Highmark, the district court focused on whether Highmark "presented or caused to be presented" the claims to the government.[30] The government argued that Highmark caused the claims to be presented to the government because Highmark's incorrect denials of primary payer status caused providers to present the same claims to Medicare for payment, which Medicare then paid as the primary payer.[31] The court noted that a "but for" analysis was likely not sufficient to prove a chain of causation under the FCA, but nonetheless it denied Highmark's motion, which would allow the government a chance to demonstrate a chain of causation.[32] Rather than risk further litigation, Highmark eventually refunded $2.5 million to Medicare and later settled the case for an additional $2 million.[33]

Relators also have brought several FCA actions accusing providers of failing to meet MSP requirements.[34] In 2007, the government settled with Harris County Hospital District for approximately $15 million for FCA claims based on

alleged violations of the MSP.[35] The relator, a patient account representative,[36] claimed that when a liability policy was involved, the defendant hospital's practice was to file a lien with the insurer while simultaneously billing Medicare as the primary payer.[37] The relator alleged that the hospital then would attempt to settle the lien as though the liability insurer was the secondary payer—i.e., settling the lien for amounts remaining after Medicare's payment, such as copayments, deductibles, and non-covered services.[38] The relator also accused the hospital of failing to use appropriate coding that would have alerted Medicare to its potential secondary payer status when submitting the claims to Medicare.[39]

More recently, relators have pursued claims against no-fault, liability, and workers' compensation insurers. In one recently unsealed case, a relator sued more than 50 insurance companies alleging FCA claims based on violations of the MSP.[40] The relator based his accusations on his experience as a personal injury attorney settling lawsuits in the liability insurance field.[41] The relator alleged that the defendant insurance companies avoided reimbursing Medicare for conditional payments and failed to consider Medicare's interests in settlements of payments for future medical care.[42] After defendants raised concerns that the relator had no personal knowledge of any false claims or of a scheme to withhold payments to which Medicare was entitled, a U.S. Magistrate Judge recommended that the federal court dismiss the case with prejudice as to the relator.[43]

In a similar case, also recently unsealed, a relator that served as a compliance consultant brought FCA claims against 18 liability, no-fault, and workers' compensation insurers and self-insured plans.[44] The relator alleged that he consulted with each of the defendants and advised them of the MSP mandatory reporting requirements.[45] The relator alleged that during his consultations with the defendants he learned that each did not have an MSP compliance program in place, and that following his consultation the defendants failed to take steps to correct their non-compliance.[46]

The government declined to intervene in both of these recent cases, but these cases show that the new reporting requirements caught the attention of whistleblowers. As CMS and payers collect and exchange more COB data pursuant to the MSP requirements, CMS and payers will become increasingly aware of which claims have potential multiple payers. At the same time, many payers and providers are still catching up with CMS' escalating enforcement of the MSP.

Although the MSP-FCA action has not yet been tested in an appellate court, such actions are becoming more common. Just as the use of the federal Anti-Kickback Statute as a basis for FCA actions steadily increased until it became codified with the passage of the Affordable Care Act,[47] we also may see the increased use of the MSP as a basis for FCA actions. Relators' counsel may even assert MSP allegations in FCA cases against payers', providers', and even plaintiffs' counsel that fail to comply with the MSP in the submission, processing, or settlement of claims. CMS, which lacked the manpower to enforce the MSP in the past, is likely thrilled to have the assistance.[48]

Payers and Providers Should Take Steps to Ensure Compliance with the MSP

Payers and providers would be wise to take cautionary measures to ensure compliance with the MSP. Payers (i.e., health plans) should create and implement policies and procedures to:

- Specify that the health plan will pay as the primary payer in accordance with the MSP;
- Provide for training to relevant personnel on the MSP's requirements;
- Obtain information relevant to COB with Medicare, including employee size for group health plan customers;
- Send questionnaires and follow-up questionnaires to beneficiaries as needed to obtain information pertaining to COB;
- Update COB information in a timely manner to reflect the MSP information gathered by the health plans;
- Adjust previously paid claims as needed when information has changed; and
- Notify CMS of claims the health plan paid secondary in error within the time period allotted.

Did You See . . .

. . . the U.S. Government Accountability Office, July 2014 Report: Medicare Advantage: CMS Should Fully Develop Plans for Encounter Data and Access Data Quality Before Use?

. . . the U.S. Department of Health and Human Services, Office of Inspector General 2015 Work Plan?

. . . Centers for Medicare & Medicaid Services' (CMS') 2013 Part C and Part D Program Annual Audit and Enforcement Report?

. . . CMS' Release of Notice of Intent to Apply for Contract Year 2016 Medicare Advantage (Part C) and Prescription Drug Benefit (Part D) and Related CY 2016 Application Deadlines?

. . . CMS' Calendar Year 2015 Readiness Checklist?

Hospitals should have policies and procedures in place to:

- Use the Medicare admission questions for services furnished by a hospital and verify the collected MSP information every 90 days for recurring outpatient services;[49]
- Train patient account staff on collecting MSP information and the proper coding and submission of claims in accordance with the MSP;
- Ensure that the provider repays Medicare within 60 days after the provider receives a payment from a primary payer; and
- Note any credit balances due to Medicare on Form CMS-838, if applicable.

Payers and providers should retain a copy of records pertaining to MSP information, such as completed admission questionnaires, for at least ten years following the date of service. Payers and providers also should perform routine internal reviews and audits and take prompt corrective action as necessary to address any discovered deficiencies.

Conclusion

As CMS continues to implement the MSP and respond to the new information gathered as part of the mandatory reporting requirements, the MSP will grow in importance to those in health care compliance. While CMS previously may have lacked the manpower to enforce the MSP on a wide scale, it looks as though relators and their counsel will fill the gap by continuing to base FCA claims on violations of the MSP.

1 *See* The Complete Guide to Medicare Secondary Payer Compliance § 1.01 (Jennifer C. Jordan ed. 2013) (noting that, although the MSP became law in 1980, CMS issued little guidance on it and largely did not enforce the MSP until the new millennium).
2 *See* 42 U.S.C. § 1395y(b)(7)-(8); 42 C.F.R. § 411.22-25.
3 *See, e.g., U.S. ex rel. Rostholder v. Omnicare, Inc.*, 745 F.3d 694 (4th Cir. 2014) (ruling that federal health care program reimbursement of drugs that the relator alleged were not produced in conformance with the Food and Drug Administration's Good Manufacturing Practices did not constitute a false claim).
4 *See U.S. ex rel Hayes v. Allstate Insurance Company*, No. 1:12-cv-01015(W.D.NY); *U.S. ex rel Takemoto*, No. 1:11-cv-00613 (W.D.NY).
5 *See* 42 U.S.C. § 1395y.
6 *Id.* (b)(2)(A).
7 *Id.*
8 *Id.* (b)(1).
9 Medicare Secondary Payer Manual (MSPM), Ch. 3, § 20.2.1.
10 *Id.* § 30.
11 *See* 42 C.F.R. § 411.50(b) (defining "promptly" to mean within 120 days after the date of the service or the date the claim is filed with the insurer, whichever is earlier).
12 42 U.S.C. § 1395y(b)(2)(B)(i); 42 C.F.R. §§ 411.45, .52, .53, .175(b).
13 *See* MSPM, Ch. 3, § 30.2.
14 *See* 42 C.F.R. §§ 411.24(h), 489.20.
15 *See* 42 C.F.R. § 411.24(i).
16 *See* 42 C.F.R. § 411.25(a).
17 *See* 42 U.S.C. § 1395y; 42 C.F.R. § 411.24(c)(2), (m).
18 42 C.F.R. § 411.24(l). This requirement does not apply when the primary payer is a liability insurer or when the failure to file the claim properly is due to the beneficiary's physical or mental capacity. *Id.*
19 *See* 42 C.F.R. § 489.20(h); MSPM, Ch. 3, § 10.4.
20 *See* 31 U.S.C. § 3729.
21 *See* 31 U.S.C. § 3730(d).
22 *Id.* (b).
23 *See* 31 U.S.C. §3729(a); *Hutchins v. Wilentz*, 253 F.3d 176, 182 (3d Cir. 2001) *cert denied*, 536 U.S. 906 (2002).
24 *See* 31 U.S.C. § 3729(a)(1); U.S. Dep't of Justice, The False Claims Act: A Primer, *available at* www.justice.gov/civil/docs_forms/C-FRAUDS_FCA_Primer.pdf (noting that the amounts are adjusted for inflation and stating the current penalties as set forth above).
25 *See* 31 U.S.C. § 3730(d).
26 *U.S. ex rel. Drescher v. Highmark, Inc.*, 305 F. Supp. 2d 451 (E.D. Pa. 2004) The relator also sued Highmark in its capacities as a Medicare Part A fiscal intermediary and Part B carrier and its alleged failure to properly coordinate benefits under the MSP.
27 *Id.* at 456.
28 *Id.*
29 *Id.* at 458.
30 *Id.* at 458-60.
31 *Id.* at 458.
32 *Id.* at 460-61.
33 *See* U.S. Att'ys Off., *U.S. Attorney's Office and Highmark, Inc. Enter into Unique Agreement to Address Insurers' Obligations under the Medicare Secondary Payer (MSP) Rules*, *available at* www.justice.gov/usao/pae/News/Pr/2006/jun/highmark.html.
34 *See, e.g.*, First Amended Complaint, *U.S. ex rel. McCaslin v. Harris County Hosp. Dist.*, No. H-03-4438 (S.D. Tex.); Complaint, *U.S. ex rel. Sharp v. Eastern Oklahoma Orthopedic Center*, No. 05CV 572 TCK-SAJ (N.D. Okla.).
35 *McCaslin,* Joint Stipulation of Dismissal with Prejudice at E. 1, ¶ 1.
36 *McCaslin,* First Amended Complaint at ¶ 7.
37 *Id.* at 38.
38 *Id.* at ¶¶ 40-44.
39 *Id.* at ¶57.
40 *See* Complaint, *U.S. ex rel Hayes, v. Allstate Insurance Company,* No. 1:12-cv-01015, (W.D.NY).
41 *Hayes,* Complaint at ¶ 7.
42 *Id.* at ¶¶ 187-89.
43 *See Hayes,* Report and Recommendation at 25.
44 *See Takemoto,* Complaint.
45 *Id.* at Complaint at ¶¶ 14-16, 74-80.
46 *Id.*
47 *See* Patient Protection and Affordable Care Act, H.R. 3590, 11th Cong. § 6402(f) (2010).
48 *See* CMS Town Hall Teleconference, "Section 111 of the Medicare, Medicaid, & SCHIP Extension Act of 2007," Sept. 8, 2009 ("For liability we don't have the staffing or resources right now to do that type of program for every single liability settlement or even with certain dollar thresholds.").
49 *See* MSPM, Ch. 3, § 10.4, § 20.1.

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