Avoiding Criminal Prosecution: Effective Use of the Voluntary Disclosure Protocol

By Daniel S. Reinberg and Nancy L. Freeman

Whether through compliance audits or otherwise, health care providers frequently discover that they have received overpayments from government payors, including the Medicare and Medicaid programs. Often these overpayments are the result of innocent mistakes and not the result of fraud or program abuse. While the provider has no legal entitlement to keep an overpayment, surprisingly, hospital administrators often remark that the decision of whether to disclose and repay the overpayment is one of the most difficult decisions they face. Given the potential for criminal prosecution as a result of failing to disclose a known overpayment, the decision ought to be far more straightforward and less agonizing than some hospital administrators perceive.

In this article, we first discuss the potential sources and theories of criminal liability for failure to disclose known overpayments, even if those overpayments initially are received through an innocent mistake. We then provide a summary of the benefits and risks of providers availing themselves of the U.S. Department of Health and Human Services, Office of Inspector General's Self Disclosure Protocol (the "Protocol"), as well as some practical guidance concerning how to conduct an audit under the Protocol.

A. Criminal Liability for Failure To Disclose Known Overpayments

1. Failure to Disclose Receipt of Excess Benefits (42 U.S.C. § 1320a-7b (a) (3))

Perhaps the single most pertinent statute relating to a provider's obligation to disclose known overpayment is Section 1128B (a) (3) of the Social Security Act (42 U.S.C. § 1320a-7b (a) (3)), which provides in pertinent part:

> [W]hoever having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment . . . conceals or fails to disclose 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 punished].

This statute has been interpreted (albeit not unanimously) as imposing an affirmative obligation to *disclose* Medicare and Medicaid overpayments and provides for criminal liability for the failure to do so. While Section 1320a-7b (a) (3) requires disclosure, it does not require repayment. Violation of this statute is a felony punishable by a maximum of five years in prison and a fine of $250,000 for individuals or $500,000 for corporations.

OIG has long viewed this statute as requiring disclosure of known overpayments. (*See e.g., OIG Compliance Guidance for Hospitals*, 63 Fed. Reg. 8,987, 8,998 (February 23, 1998) ("failure to repay overpayments within a reasonable period of time could be interpreted as an intentional attempt to conceal the overpayment from the Government, thereby establishing an independent basis for a criminal violation with respect to the hospital, as well as any individuals who may have been involved.") The government's view is that when a provider concludes it has received funds to which it is not entitled, subsequent retention of the funds is a "failure to disclose" with fraudulent intent. This argument is more or less consistent with the general approach of 42 U.S.C. § 1395g(a), which requires for the calculation of Part A benefits adjustments on account of previously made overpayments, but is still untested in the courts. OIG also is likely to view this statute as creating a "continued offense," meaning that each day in which a provider fails to disclose a known overpayment presents a new offense. Under this theory, the government could argue that overpayments received many years in the past nonetheless could result in current violations of Section 1320a-7b (a) (3) if known and not disclosed.

Section 1320a-7b (a) (3) is arguably ambiguous as to the meaning of the term "fraudulently to secure." Thus, it is unclear whether a provider who innocently receives an overpayment develops the required fraudulent intent by failing to disclose the overpayment once the provider discovers it. The OIG likely will advocate a violation of the statute under these circumstances, and no court has held to the contrary. While there is a single arbitration decision in connection with a private dispute between the Healthcare Financial Advisors, Inc. and Certus Corporation in which a retired state court judge held that Section 1320a-7b (a) (3) does not apply to innocently obtained and non-recurring overpayments, the nonbinding effect of this arbitration decision and the potential criminal penalties involved make it too risky not to disclose known overpayments.

2. Criminal False Claim Act (18 U.S.C. § 287)

Section 287 of Title 18 provides for imprisonment of up to five years, a fine, or both, for any person who "makes or presents" any claim to an agency of the U.S. Government "knowing such claim to be false, fictitious, or fraudulent." This statute applies where the victim is the U.S. Government, including Medicare, Medicaid, and Tricare. There is no requirement that the submitted claim itself be false on its face, as the statute also includes "fraudulent" claims. In addition,

conspiracies to violate Section 287 are criminalized by Section 286 of Title 18, and the penalties for conspiracy are twice as severe as what can be imposed under Section 287.

In general, the same type of conduct that produce violations of the civil False Claims Act (31 U.S.C. § 3729 et seq.) could lead to criminal liability under Section 287 for providers who fail to disclose known overpayments. Under the FCA, a person may be liable for knowingly submitting a false or fraudulent claim for payment to the government. In order to impose liability, the government must prove that a "false or fraudulent" claim was "knowingly" submitted for payment or that a "false record or statement" was made in order to get a false claim paid or approved. 31 U.S.C. §§ 3729(a) (1) and (2). Notably, even in instances where an overpayment is obtained innocently, meaning that the initial claim submitted was not false on its face, FCA liability can attach under Section 3729(a) (1) based on conduct occurring after discovery of the overpayment. For instance, some courts have held that the endorsement and deposit of a government check known to have been issued in error constitutes presentation of a false claim and may subject the recipient to liability under the FCA. *See e.g., United States v. McLeod*, 721 F.2d 282 (9th Cir. 1983)

In addition, Section 3729(a)(7), which has become known as the "reverse false claim" provision, serves as a basis for liability if a person "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" to the government. Under this section, a fraudulent attempt to reduce an amount owed to the government could constitute a false claim. Thus, if a provider retains money that it knows it owes to the government, the provider could be liable under Section 3729(a) (7). This argument seems particularly strong for Part A benefits in light of the language of 42 U.S.C. 1395g (a), which indicates that ongoing Medicare payments are to include "necessary adjustments on account of previously made overpayments or underpayments …"

3. Health Care Fraud (18 U.S.C § 1347)

Title 18, Section 1347 makes it a crime to knowingly and willfully execute (or attempt to execute) a scheme to defraud any health care benefit program, or to obtain money or property from a health care benefit program through false or fraudulent pretenses, representations or promises. This statute applies to Federal health care programs and most other health care benefit programs. The penalty for a violation of this statute may include fines, imprisonment of up to ten years, or both. The prison term may be increased where the violation results in serious bodily injury or death.

This statute has been recently used to prosecute individuals engaged in alleged schemes aimed at non-profit health maintenance organizations and private insurance companies. *See e.g., United States v. Baldwin*, D.D.C. No. 02-0323 (PLF) (August 14, 2003) (indictment for scheme to defraud Kaiser Foundation Health Plan Inc., a non profit health maintenance organization); *United States v. Murphy*, N.D. Tex, No. 4:02-CR-011-Y (defendant physician convicted in May 2003 of submitting more than one million dollars in fraudulent medical claims to insurance companies between 1996 and 2000 for services he did not provide or supervise at medical clinics located in health clubs).

In the case of the failure to disclose a known overpayment, the government may view the failure to disclose the overpayment as evidence of fraudulent intent present at the time the initial claims were submitted. In cases where the overpayment undeniably resulted from an innocent mistake, the government may still seek to define a "scheme" to defraud in terms of the concealment that occurs after knowledge of the overpayment. For instance, providers who are audited by outside auditors are routinely asked questions that should reasonably call for disclosure of the overpayment to the auditors. In instances where this information is withheld from the auditors or false information is provided to the auditors, the government likely will view this as active concealment and, thus, evidence of a scheme to defraud beginning at least at the time of the concealment.

4. Other Federal Criminal Statutes

There are a host of other federal criminal statutes that could be used by the government to prosecute a health care provider (and/or individuals) for failure to disclose known overpayments. While not an exhaustive list, some of the most commonly used criminal statutes are as follows: (a) Mail Fraud (18 U.S.C. § 1341); (b) Wire Fraud (18 U.S.C. § 1343); (c) False Statements Relating to Health Care Matters (18 U.S.C. § 1035); (d) Embezzlement of Public Money or Property (18 U.S.C. § 641); (e) Embezzlement in Connection with Health Care (18 U.S.C. § 669); (f) Concealment of Material Fact (18 U.S.C. § 1001); and (g) Misprision of a Felony (18 U.S.C. § 4).

B. Effective Use of The Voluntary Disclosure Process

Once the decision has been made that use of the process is necessary, it is key that legal representation experienced with the use of the protocol be sought. Mistakes, such as reporting too early in the process before the extent of the issue is fully understood or reporting to the wrong governmental forum, can have significant short term and long term ramifications for the organization. Experienced legal counsel can help a provider to avoid these land-mines and guide you through the required steps which are as follows:

Process Analysis. The process analysis involves conducting an intense investigation of the issue to determine how the issue was discovered, how long has the issue existed, who knew, who should have known, and what corrective action has been taken. Generally, this information is gathered through a series of interviews and use of other investigative techniques. Although generally conducted under the guidance of legal counsel, the interviews are often conducted either by counsel or external consultants knowledgeable of the specific issue at hand.

Testing. The testing phase is defined by a specific statistical protocol utilizing a probe sample and if appropriate followed by a full sample. The protocol recommends the use of RAT-STAT for purposes of sample selection, but other statistical methodologies can be used as long as approved by the appropriate governmental entity. External consultants are often utilized in this phase of the engagement for purposes of independence and statistical expertise.

Reporting. Reporting requirements are also defined within the protocol. Failure to follow the specific reporting requirements or to provide vague or less than complete answers generally results in follow up questions from the various governmental entities involved and may require additional work on the part of the reporting entity. Report generation is usually under the guidance of legal counsel but will generally involve any external consultants as well.

Outcomes from use of the voluntary disclosure protocol can be varied. In the

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departments, delivers more efficient and effective recommendations, and provides process documentation, for example, process mapping, to the organization.

Risk Management: Internal audit helps develop a common risk language, facilitates organization-wide risk prioritization efforts, and performs process mapping. Like process, risk management offers more value and takes a different focus from the internal audit function.

ERM: Internal audit takes a more holistic view of organizational governance and aligns its skills and activities to assess, improve, and monitor a healthcare entity's organizational governance capabilities. To accomplish this successfully, a CAE would be fully aligned with all aspects of an organization's governance processes.

The higher the level a healthcare organization reaches in aligning with its internal audit function, the better for its risk management, capabilities, and compliance perspectives. However, CAEs have to understand what role their organization wants them to play and customize their approach to the distinctive characteristics of their individual organizations.

For example, internal auditors have to consider each healthcare organization's maturity, business strategy, capabilities, not-for-profit or for-profit culture, and competitive position in the industry. And these factors will continually evolve, so the overall internal audit approach must be adaptable to change — subtly or dramatically — as the circumstances dictate.

Conclusion

An internal audit function cannot be at the ERM, or advanced, level if its organization is not there yet. And internal audit cannot successfully perform at the strategic level if it is not performing well at all the other levels in the spectrum.

Tolerating calculated risks does result in rewards. No healthcare organization wants an internal audit group whose only response to risks is to prevent them entirely. Every business venture has risks. That is where internal auditing can add more value by knowing which risks are acceptable and which ones are not. Internal auditors have to be ready to accommodate changes within their healthcare organizations.

Even more important to operating at the strategic level, internal auditors need to understand all facets of a business, and possess keen insight, discerning judgment, and skillful diplomacy. **NP**

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best case scenario, when the government believes the provider has been open and honest in their dealings, the issue was accidental, and has a functioning compliance program in place to prevent future incidents, the provider may only have to pay back overpayments with no associated fines or penalties. In the worst case, the provider may have to pay significant fines and penalties, have a corporate integrity agreement for five years with rigorous reporting requirements, and the case may be referred for criminal prosecution. Having experienced legal representation to guide the process can assist the provider along the way in putting the appropriate controls in place to mitigate the risk of increased fines, penalties, and criminal prosecution.

Conclusion

There are significant risks and benefits that must be factored into the decision to disclose a known overpayment. While the facts of each case will be determinative, given the legal framework described above, in most cases the better course of conduct when an overpayment is discovered is to take immediate corrective action, including disclosing the past misconduct and making reparation for an appropriate period and in an appropriate amount. How and when the disclosure is made will vary from case to case depending upon the circumstances, though in recent years providers have obtained positive results through the OIG Self Disclosure Protocol. **NP**

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