OCTOBER 2015 • VOL. 16, NO. 10
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The Society for Post-Acute and Long-Term Care Medicine

AN OFFICIAL PUBLICATION OF AMDA – THE SOCIETY FOR POST-ACUTE AND LONG-TERM CARE MEDICINE

Caring for the Ages

A Monthly Newspaper for Long-Term Care Practitioners

In This Issue

Societies Help Guide LGBT Care Conversation

BY JOANNE KALDY

With same-sex marriage now the law of the land, many PA/LTC facilities are seeking to implement policies and other initiatives to ensure and promote a safe, welcoming environment for lesbian, gay, bisexual, and transgender elders. Those who question the need or value of these policies may want to talk to Vassar Byrd, CEO of Rose Villa Senior Living in Portland, OR. After a radio spot aired about the community as a welcoming place for LGBT seniors, a delivery person came to Ms. Byrd in tears.

"He said how comforting it was for him to know that his sister could have a safe place to live where she could be herself," she recalled. A current resident also responded to the ad, noting that "he was proud to be affiliated with us because he had a gay son," Ms. Byrd noted. "We hear sentiments such as these all the time."

PHOTO COURTESY OF ROSE VILLA SENIOR LIVING

A facility's policies toward LGBT residents should be stated clearly at admission, and guide new residents into a welcoming, open environment.

Societies Offer Guidance

With facilities increasingly seeking guidance on ensuring quality care and safety for LGBT residents, organizations such as AMDA and the American Geriatrics Society have stepped up to the plate with resources. Most recently, AGS released a position statement entitled "Care of Lesbian, Gay, Bisexual, and Transgender Older Adults." The document outlines an action plan for organizations, advocacy groups, and medical specialties committed to discrimination-free health care. These measures include:

- Encouraging health providers and their institutions to create, evaluate, and publicize policies for equal treatment of LGBT patients regardless of age.
- Implementing LGBT health training programs for professionals who treat older individuals.
- Supporting high-quality research addressing LGBT health and discrimination.
- Ensuring that older LGBT adult care reflects the particular health care and social circumstances these patients face, including the role of partners and chosen family members in health decisions and the need for a supportive culture of respect.

"The theme is to always be aware, open, and respectful. Try to be aware of and avoid instances where you might make assumptions about someone's traditions or experiences," said Joseph Shega, MD, chair of the AGS ethics committee responsible for the statement. "As providers, we take an oath to provide high-quality, person-centered care for all people from all walks of life. That is

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Overpayment Ruling Could Lead to Liability Lawsuits

BY ALICIA GALLEGOS

In a novel decision, the U.S. District Court for the Southern District of New York has ruled that the 60-day clock to return overpayments to the government begins ticking when a health care provider receives notice that a potential overpayment exists, not when an overpayment is conclusively ascertained.

Doctors should be concerned about the ruling, said Houston health law attorney Michael E. Clark, immediate past chair for the American Bar Association Health Law Section.

"This is a very troubling development because the judge has embraced the theory that certainty is not required as to what constitutes an identified overpayment," Mr. Clark said in an interview. "Rather, knowledge can be established by recklessness under the facts. In short, practitioners must set up systems to alert them about potential overpayments so they can move quickly to avoid potentially ruinous False Claims Act liability."

The Aug. 3 ruling in *Kane v. Healthfirst* is the first published decision to address the 60-day overpayment rule imposed under the Affordable Care Act and the Fraud Enforcement and Recovery Act (FERA). The rule requires that an overpayment be reported and returned by health providers within 60 days of the "date on which the

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Overpayment

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overpayment was identified." Health providers who retain an overpayment beyond that point are subject to liability under the False Claims Act (FCA).

60-Day Limit

In the Kane case, the federal government contends that three hospitals operated by Continuum Health Partners failed to report and return overpayments to Medicaid within 60 days of identification. Because of a computer glitch, Continuum billed both the government and a managed care organization for the same services, according to court documents. After the New York State Comptroller's Office alerted Continuum to a possible overbilling, Continuum hired an employee, Robert P. Kane, to conduct an internal investigation into its billing. Mr. Kane — who was later fired — allegedly found 900 potentially improper Medicaid claims totaling $1 million, according to court documents. The government claims Continuum failed to repay the overpayments within 60 days and instead repaid only "small batches" of the affected claims over the next 2 years. Mr. Kane filed a whistleblower suit against Continuum, and the government intervened as a plaintiff.

To protect themselves from litigation, physicians should take prudent steps to conduct an appropriate investigation if faced with actual or constructive notice of a possible overpayment.

But Continuum argued that the hospitals did not knowingly conceal the overpayments from the government, and that the overbillings had not been officially "identified." The defendants were provided only notice of potential overpayments and did not identify actual overpayments so as to trigger the 60-day report and return clock, Continuum said in court documents. The health system requested the court throw out the government's suit for lack of merit.

District Judge Edgardo Ramos agreed with the federal government and allowed the lawsuit to continue. Judge Ramos said the legislative history indicates that Congress intended for FCA liability to attach in circumstances where there is an established duty to pay money to the government, even if the precise amount due has yet to be determined.

"Here, after the comptroller alerted defendants to the software glitch and approached them with specific wrongful claims, and after Kane put defendants on notice of a set of claims likely to contain numerous overpayments, defendants had an established duty to report and return wrongly collected money," Judge Ramos said in his opinion. "To allow defendants to evade liability because Kane's email did not conclusively establish each erroneous claim and did not provide the specific amount owed to the government would contradict Congress' intentions as expressed during the passage of the FERA."

In an email, a spokesperson for the defendants said the hospitals are disappointed with the judge's decision and will continue to vigorously defend its case in court. Attorneys for the government did not return messages seeking comment.

The judge's ruling is encouraging to the federal government and for plaintiffs who wish to sue health providers for overbilling violations, said Joel M. Androphy, a Houston plaintiffs' attorney.

"This is going to open the floodgates for lawyers now as part of their false claim and reporting practices to let the courts know about overpayment issues because they know the court and the government will be listening," Mr. Androphy said in an interview. "It's not going to be the sole basis for [a plaintiff's] claim necessarily, but it could be an integral part."

Ball of Confusion

Mr. Androphy added that defendants can no longer complain they were confused by the 60-day overpayment rule and the meaning of "identification." The judge's ruling makes the regulation more clear and provides guidance to health providers about how the rule will be enforced, he said.

Washington health law attorney Robert T. Rhoad, however, disagreed that the opinion clarifies application of the 60-day overpayment rule. The decision does not provide the bright lines for compliance that providers expect and need, said Mr. Rhoad.

"While the Kane decision provides an exposition of the etiology and perceived intent of the 60-day rule, its ultimate ruling was made through the narrow lens of the specific and arguably egregious [facts] alleged," Mr. Rhoad said in an interview. "If anything, by finding that certainty is not required in identifying an overpayment triggering the 60-day rule, the decision may encourage the government and qui tam relators to come forward with expansive theories of what might constitute reckless disregard by a provider to identify an overpayment to invoke FCA liability by the running of the 60-day clock."

To protect themselves from litigation, physicians should take prudent steps to conduct an appropriate investigation if faced with actual or constructive notice of a possible overpayment, Mr. Rhoad said. Showing that they acted with due diligence and without delay to investigate and, if identified, report an overpayment could help doctors withstand future governmental or judicial scrutiny.

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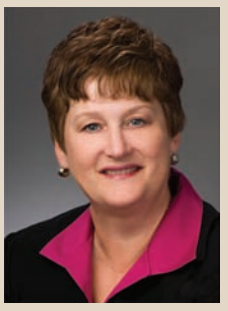
PA/LTC Perspective



Health care providers and the legal community are buzzing about the ramifications of the denial of a motion to dismiss in *Kane v. Healthfirst*, a case in federal court before the Southern District of New York. The Kane case was filed by a whistleblower against his former hospital employer. While the court's analysis sheds some light on the timing of overpayment return by providers, questions still remain.

The Patient Protection and Affordable Care Act (ACA) requires providers to report, return, and explain overpayments to government payers within 60 days after an overpayment has been identified. If a provider does not return the overpayment within the notice period, the government can pursue civil money penalties against the provider. An ongoing question is, precisely how does a provider know when an overpayment has been identified? Without this information, it is impossible to know when the 60-day notice period begins or, more importantly, ends.

The government has yet to issue a rule clearly defining "identification of an overpayment." In 2012, the Centers for Medicare & Medicaid Services proposed a rule that included such a definition, but that rule has never been finalized. As a result, providers and the courts are left with little clarity surrounding this important issue.

The Kane decision, written by Judge Ramos, includes very detailed factual and legal analysis in support of the court's decision to deny the defendant's motion to dismiss. The court's reasoning, however, does not eliminate much of the ambiguity surrounding the 60-day notice period. Providers should keep in mind the following points when interpreting the 60-day repayment requirement:

- Individual physicians, as well as health care organizations, must be aware that the 60-day repayment requirement necessitates action by the provider.
- Investigate all complaints/concerns called to the hotline, dropped in the complaint box, or verbally brought to the attention of the organization. Do not delay investigating issues brought to the provider's attention.
- Act promptly to analyze and make a determination regarding any potential overpayments. Promptly repay the overpayment amount within a conservative estimate of the 60-day notice period.
- Be aware that potential whistleblowers may be watching your organization's response to potential overpayment issues.
- Monies must be returned for any overpayment. Delaying return of monies may result in significant liability.

Providers and the health care legal community will continue to watch this dynamic area of the law because of the potential impact on health care providers' billing and compliance practices.

—Janet Feldkamp, JD, RN, LNHA
Benesch Friedlander Coplan & Aronoff LLP
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ACOs Generate Savings, But Not Shared Savings Payments

BY GREGORY TWACHTMAN

Accountable care organizations accounted for savings of more than $411 million in 2014, according to the Centers for Medicare & Medicaid Services.

However, of the 20 Pioneer ACO programs and the 333 ACOs participating in the Medicare shared savings program, just 97 qualified for shared savings payments of more than $422 million by meeting quality standards and their saving threshold, according to a report from CMS.

In addition to savings, provider groups also reported improvement on certain quality metrics. For those in the Pioneer ACO program, groups demonstrated improvement on 28 of 33 quality measures and experienced a 3.6% improvement across all quality measures, compared with the previous year. Top areas of improvement were medication reconciliation, screening for clinical depression and follow-up plan, and qualification for electronic health record incentive payments.

For ACOs participating in the Medicare Shared Savings program, improvement was shown in 27 of 33 quality measures, including patients' ratings of clinicians' communication, patients' ratings of their doctors, screening for tobacco use and cessation, screening for high blood pressure, and electronic health record use.

"Accountable care organizations as a group are on the path toward transforming how care is provided," CMS Acting Administrator Andy Slavitt said in a statement. "Many of these ACOs are demonstrating that they can deliver a higher level of coordinated care that leads to healthier people and smarter spending."

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