Playing Hot Potato with Overpayments:

Health Care Providers Must Act Quickly to Refund Overpayments or Risk FCA Liability

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In June 2014, the U.S. Attorney's Office for the Southern District of New York intervened in a False Claims Act (FCA) qui tam against several New York hospitals alleging that they violated the FCA by improperly retaining certain overpayments (hereinafter, the *Healthfirst* case).[1] *Healthfirst* marks the first time that the government has intervened in an FCA action based upon an alleged violation of the "60-day rule." That rule was passed as part of the Affordable Care Act (ACA) and extends FCA liability, under a reverse false claims theory, to any individual or entity that fails to report and refund an overpayment within 60 days of identification.[2] Importantly, as long as the individual or entity acts with the requisite knowledge under the FCA (actual knowledge, reckless disregard, or deliberate ignorance), FCA liability can be imposed even where the individual or entity received the overpayment through no fault of its own. This article discusses the 60-day rule, the potential consequences of failing to comply with that rule, and other related issues that are pending before the court in *Healthfirst*.

"Reverse False Claims" Theory of Liability

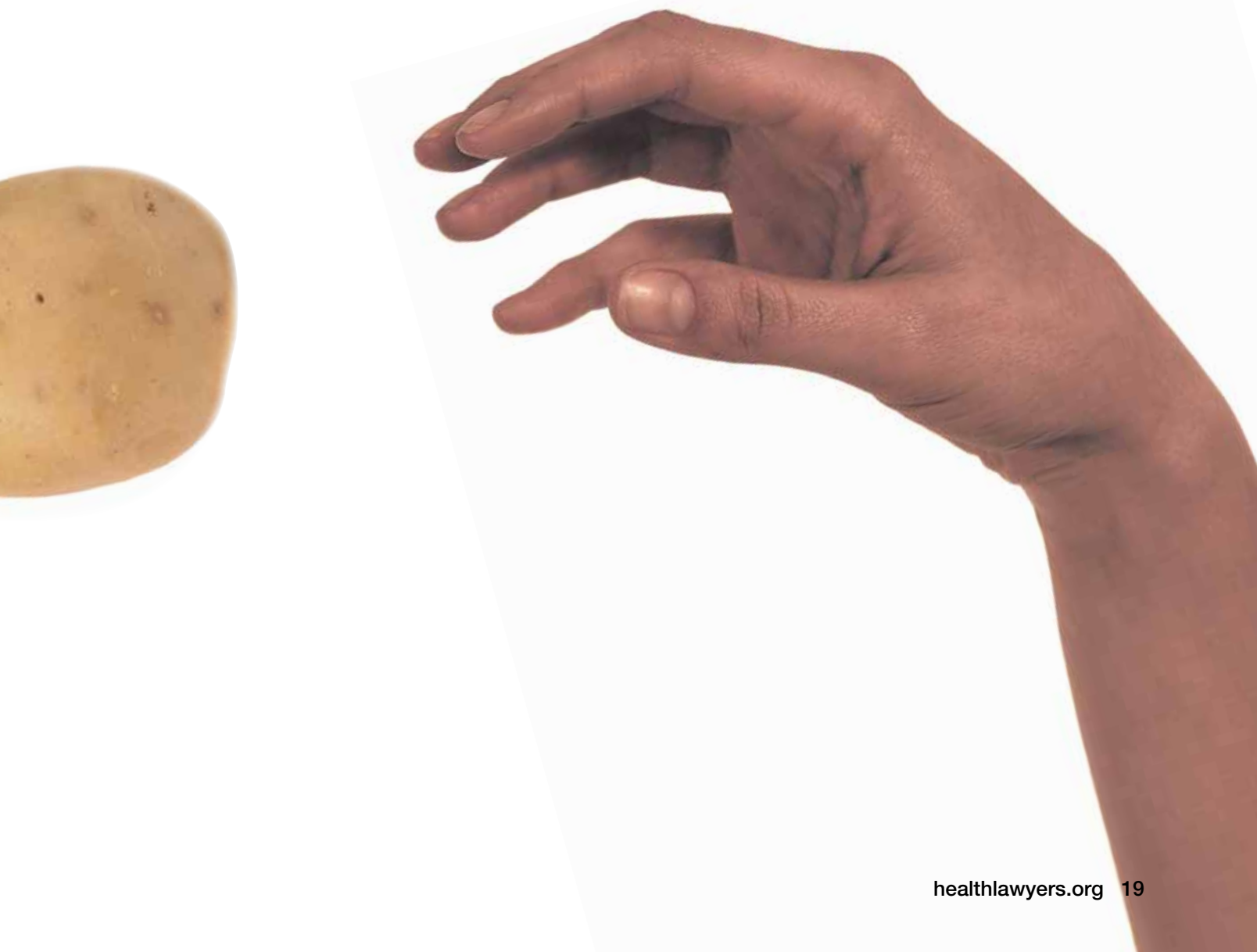
Although the FCA is perhaps best known for its provisions establishing liability for submitting false or fraudulent claims

to the government,[3] or making or using false records or statements in connection with such a claim,[4] a lesser known provision is the "reverse false claims" provision, which establishes liability for any person who "knowingly conceals or knowingly and improperly avoids or decreases an *obligation* to pay or transmit money or property to the Government."[5] The FCA defines the term "obligation" to include "the retention of any overpayment."[6] Although a narrower version of the reverse false claims provision existed since 1986, it was not until 2009 when Congress—through the Fraud Enforcement and Recovery Act (FERA)—amended the FCA to make clear that the retention of an overpayment could lead to FCA liability.[7] Like other provisions of the FCA, the reverse false claims provision includes the threat of treble damages and substantial per-claim penalties.[8]

Background on the 60-Day Rule

In 2010, Congress once again upped the ante when—as part of the ACA—it amended the Social Security Act (SSA) to provide that when a person receives an overpayment, that overpayment must be "reported and returned" within 60 days after the date on which the overpayment is "identified," or the date any corresponding cost report is due, whichever comes later.[9] Congress made clear that "[a]ny overpayment retained by a person after the deadline for reporting and returning the overpayment . . . is an obligation" for purposes of the FCA.[10] Importantly, the SSA does not require any wrongdoing in relation to the receipt of an overpayment. Instead, the SSA broadly defines "overpayment" as "any funds that a person receives or retains under [the Medicare or Medicaid subchapters] to which the person, after applicable reconciliation, is not entitled under such subchapter."[11] Accordingly, if a provider retains an overpayment for more than 60 days after the date on which it was identified, that provider faces potential FCA liability even if the provider received the overpayment innocently.

Further, in its proposed rule implementing the 60-day rule, the Centers for Medicare & Medicaid Services (CMS) included a ten-year look back period requiring a provider to report and return an overpayment if that overpayment is identified



within ten years of the date it was received.[12] CMS issued its proposed rule implementing the 60-day rule for purposes of Medicare Part A and B overpayments on February 16, 2012.[13] The comment period for that proposed rule closed in April 2012, and the proposal was due to be finalized no later than February 16, 2015—three years after the initial proposal.[14] However, on February 17, 2015, CMS extended the timeline for publication of the final rule by one year—until February 16, 2016—noting that, "[b]ased on both public comments received and internal stakeholder feedback . . . there are significant policy and operational issues that need to be resolved in order to address all of the issues raised by comments to the proposed rule and to ensure appropriate coordination with other government agencies."[15] The one-year delay of the final rule does not mean, however, that healthcare providers cannot face liability for violating the 60-day rule. As CMS expressly states in its notice: "even without a final regulation [stakeholders] are subject to the statutory requirements found in [the ACA] and could face potential False Claims Act liability, Civil Monetary Penalties Law liability, and exclusion from Federal health care programs for failure to report and return an overpayment."[16]

Importance of the Healthfirst Case

Although the 60-day rule has been law since 2010 and, as CMS makes clear in its February 2015 notice, can lead to FCA and other liability even without a final regulation, the *Healthfirst* case is important because it represents the first time the government has intervened in an FCA qui tam based upon an alleged violation of that rule. As such, the outcome of the *Healthfirst* case will be the beginning of precedent on interpretation and application of the 60-day rule and potential FCA liability.

Until this issue works its way through the courts, providers and their attorneys must work extremely quickly to identify the full extent of, and fully report and refund, any overpayments to Medicare and Medicaid at the first sign of a potential overpayment or risk liability under the FCA and other fraud and abuse statutes.

Factual Background

The hospital defendants in *Healthfirst* contracted with a Managed Care Organization to issue electronic remittances that contained codes indicating whether the hospitals could seek additional payment from secondary payers such as Medicaid.[17] According to the government's complaint, beginning in 2009 as the result of a software glitch, the remittances contained coding that erroneously indicated that the hospitals could seek additional payment from a secondary payer where such additional payments were not allowed.[18] As a result, the hospitals' electronic billing programs automatically generated bills to secondary payers, including Medicaid, where no secondary billing was appropriate.[19]

According to the complaint, in September 2010, auditors from the New York Comptroller's office questioned the hospitals regarding a small number of claims that allegedly had been improperly submitted to the New York State Department of Health (DOH) for Medicaid reimbursement.[20] Subsequent discussions between the Comptroller, the hospitals, and the software vendor revealed the cause of the problem, and the software vendor issued a corrective software patch in December 2010.[21]

After the problem was discovered, hospital management asked Robert Kane (later Relator Kane) to ascertain which claims had been improperly submitted to Medicaid as a result of the software error.[22] In late 2010 and January 2011, Kane and others began analyzing billing data to identify all possibly affected claims.[23] In January 2011, the Comptroller informed the hospitals of several additional improperly billed claims.[24] Then, on February 4, 2011, Kane emailed a spreadsheet to hospital management that contained more than 900 claims (totaling over $1 million) that Kane identified as containing the erroneous billing code.[25] According to the government's complaint "[w]hile Kane's email indicated that further analysis was needed to corroborate his findings, Kane had successfully identified the vast majority of claims that had been erroneously billed."[26] Four days later, the hospitals terminated Kane's employment and, according to the government, "did nothing further with Kane's analysis or the claims identified therein."[27] That month, the hospitals reimbursed DOH for only five of the allegedly improperly submitted claims.[28]

According to the government's complaint, the Comptroller continued to analyze the hospitals' billing over the course of the following year, and identified several additional groups of affected claims.[29] Starting in March 2011 and continuing through February 2012, the Comptroller brought these additional affected claims to the hospitals' attention.[30] Importantly, the government's complaint acknowledges that the hospitals began to reimburse DOH for some of the allegedly improperly billed claims.[31] In fact, the government's complaint states that the hospitals reimbursed DOH "for claims improperly billed to Medicaid in more than thirty tranches after February 2011, beginning in April 2011 and concluding only in March 2013."[32] Notwithstanding, the government characterized this as evidence that the hospitals were "fraudulently delaying [their]

repayments for up to two years" after they knew of the extent of the overpayments, and further noted that the hospitals reimbursed many of the affected claims only after receiving a Civil Investigative Demand from the Department of Justice seeking information.[33] According to the government, the hospitals "intentionally or recklessly failed to take the necessary steps to timely identify the claims affected by the softwa issue or to timely reimburse DOH for those affected claims that resulted in overbilling to Medicaid."[34] The government's complaint asserted one count against the defendants for viola tion of the FCA's reverse false claims provision.[35]

The Parties' Arguments Concerning the 60-Day Rul

On September 22, 2014, the defendants in *Healthfirst* moved to dismiss the government's complaint under Federal Rules o Civil Procedure 9(b) and 12(b)(6), arguing, in relevant part, that:[36] :

> The Complaint relies heavily (if not exclusively) on an email communication from [Relator Kane] to a group of his colleagues . . . to support the Government's contention that Defendants' failure to make unspecified repayments quickly enough thereafter constituted a violation of the FCA. However, as the Complaint itself acknowledges, Kane's email did not specifically identify any overpayments. Instead, it attached a preliminary list identifying the universe of claims that were potentially affected by a bill coding error caused by a third party, without indicating whether those claims were billed to or paid by the Government. A separate schedule . . . shows that approximately half of the claims on Kane's email list were not billed or paid.
>
> Under [the ACA's 60-day rule], mere notice of a potential overpayment does not give rise to an "established duty" until 60 days after the overpayment is "identified" (*i.e.*, when the healthcare provider has actual knowledge of the overpayment). Because the list did not "identify" any overpayments, it did not give rise to any "established duty," and thus did not create an "obligation" that is a prerequisite for liability.[37]

The defendants also note that even the government's complaint characterized Kane's email as identifying claims that "*may have been* wrongly submitted to and paid by Medicaid[.]"[38] According to the defendants, both the statutory scheme and legislative history of the 60-day rule demonstrate "that a preliminary report like Kane's that only identifies potential overpayments (as opposed to actual confirmed overpayments) does not start the 60-day clock to establish an 'obligation' under the statute."[39]

The defendants further note that most health care providers would have to take numerous steps after receiving notice of a potential overpayment to identify an actual overpayment, illustrating "why requiring the reporting and return of overpayments within 60 days of such notice imposes an enormous burden on providers that may often be impossible to meet."[40] According to the defendants,

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the initial steps needed to identify an overpayment include: (1) a review of the findings by retrieving and reviewing the medical records involved; (2) discussing the cases with the furnishing physicians; and (3) consulting with staff with expertise in coding and, possibly, counsel.[41] Even then, if the initial review confirms an overpayment, it might then be necessary to extend the review to claims outside of the initial sample.[42] Once the review identifies actual overpayments, the provider's reimbursement staff would then have to make arrangements to return the overpayments, which may require identifying specific claims giving rise to an overpayment by claim number and other identifying information.[43]

Additionally, the defendants argue that the government failed to allege that the defendants knowingly "concealed", or knowingly and improperly "avoided" or "decreased," an obli-

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gation as required by the reverse false claims provision, even if an obligation existed.[44] According to the defendants, the alleged wrongdoer must take some affirmative action in order to "conceal," "avoid," or "decrease" an obligation; an obligation cannot be concealed, avoided, or decreased through inaction.[45] Because the government's complaint did not allege any affirmative action taken by the defendants to prevent the disclosure of purported overpayments, but instead alleged inaction, the defendants argue that they did not violate the FCA.[46]

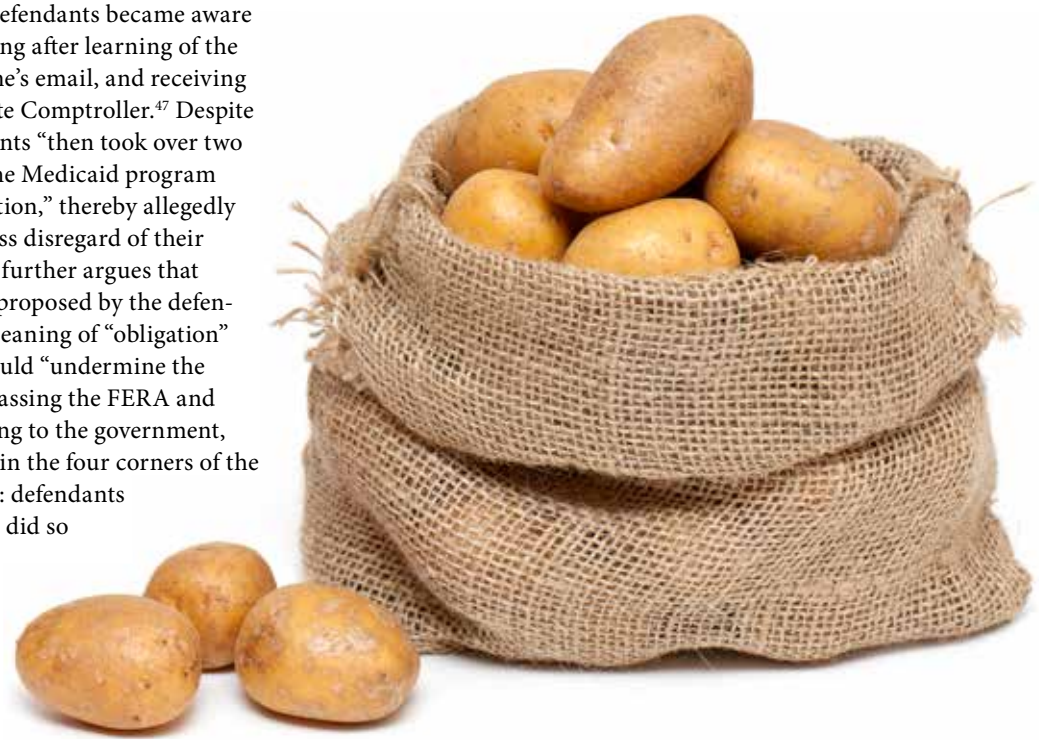
In opposition to the defendants' motion to dismiss, the government argues that the defendants became aware of the extent of their overbilling after learning of the software glitch, receiving Kane's email, and receiving additional alerts from the state Comptroller.[47] Despite this information, the defendants "then took over two years . . . to fully reimburse the Medicaid program for the overpayments in question," thereby allegedly acting in knowing and reckless disregard of their obligation.[48] The government further argues that the definition of "identified" proposed by the defendants would contradict the meaning of "obligation" contained in the FCA and would "undermine the clear intent of Congress" in passing the FERA and ACA amendments.[49] According to the government, the conduct at issue "fits within the four corners of the reverse false claims provision: defendants retained an overpayment and did so 'knowingly,' i.e., in reckless disregard to their duty to return the funds."[50]

The Current State of Uncertainty

As the briefing in *Healthfirst* makes clear, there are many unanswered questions related to the 60-day rule—most importantly, there are uncertainties that have left health care providers and their attorneys in limbo with regard to the exact definition of "identify" so as to trigger the 60-day clock to return overpayments. The court in *Healthfirst* will hopefully clarify the term "identify" when issuing a ruling on the defendants' motion to dismiss. In the meantime, the guidance the provider community has on the issue of when an overpayment is "identified" is CMS' 2012 proposed rule, in which CMS explained that an overpayment is "identified" for purposes of the 60-day rule "at the time a person acts with actual knowledge of, in deliberate ignorance of, or with reckless disregard to the overpayment's existence."[51] According to that proposed rule:

In some cases, a provider or supplier may receive information concerning a potential overpayment that creates an obligation to make a reasonable inquiry to determine whether an overpayment exists. If the reasonable inquiry reveals an overpayment, the provider then has 60 days to report and return the overpayment. On the other hand, failure to make a reasonable inquiry, including failure to conduct such inquiry with all deliberate speed after obtaining the information, could result in the provider knowingly retaining an overpayment because it acted in reckless disregard or deliberate ignorance of whether it received such an overpayment.[52]

Unfortunately, these statements from CMS tend to raise more questions than they resolve. Even with this guidance, health care providers and their attorneys are still left with very important questions, such as what it means to make a "reasonable inquiry" and when a provider acts with "all deliberate speed." The fact that implementation of the proposed rule has been delayed for an additional year exacerbates the confusion.



One possibility is that the court in *Healthfirst* will draw an analogy to recently finalized regulations concerning the meaning of "identify" for purposes of overpayments in the Medicare managed care context.[53] Those regulations provide that an Medicare Advantage (MA) organization "has identified an overpayment when the MA organization has determined, or should have determined through the exercise of reasonable diligence, that the MA organization has received an overpayment."[54] As the government notes in its *Healthfirst* briefing, although these regulations are not directly applicable outside of the managed care context, they could be a helpful tool in determining what the 60-day rule means when it uses the word "identified." However, even if a court adopts this definition, there would still be an open question as to when a provider "should have determined [that it received an overpayment] through the exercise of reasonable diligence."[55]

Regardless of how the court in *Healthfirst* rules on this and other issues, there is certainly no guarantee that other courts will agree in future cases. A potential split in authority would leave health care providers and their attorneys in continued limbo regarding what steps must be taken to identify potential overpayments, as well as when, and under what circumstances, a health care provider will be deemed to have "identified" an overpayment for purposes of triggering the 60-day clock. Until this issue works its way through the courts, providers and their attorneys must work extremely quickly to identify the full extent of, and fully report and refund, any overpayments to Medicare and Medicaid at the first sign of a potential overpayment or risk liability under the FCA and other fraud and abuse statutes.

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Endnotes

1 Complaint–In-Intervention, *United States v. Continuum Health Partners, Inc., et al.,* Civil Action No. 11-2325 (S.D.N.Y. June 27, 2014).
2 42 U.S.C. § 1320a-7k(d).
3 31 U.S.C. § 3729(a)(1)(A).
4 *Id.* § 3729(a)(1)(B).
5 *Id.* § 3729(a)(1)(G) (emphasis added).
6 *Id.* § 3729(b)(3).
7 Pub. L. No. 111-21, S. 396, 123 Stat. 1617.
8 31 U.S.C. § 3729(a)(1).
9 42 U.S.C. § 1320a-7k(d)(1), (2).
10 *Id.* § 1320a-7k(d)(3).
11 *Id.* § 1320a-7k(d)(4)(B).
12 77 Fed. Reg. 9184 (Feb. 16, 2012).
13 77 Fed. Reg. 9179 (Feb. 16, 2012).
14 80 Fed. Reg. 8247 (Feb. 17, 2015).
15 *Id.* at 8248.
16 *Id.*
17 Complaint-In-Intervention, *supra* note 1, at ¶¶ 29-30.
18 *Id.* at ¶ 31.
19 *Id.*
20 *Id.* at ¶ 33.
21 *Id.*
22 *Id.* at ¶ 34.
23 *Id.*
24 *Id.*
25 *Id.* at ¶ 35.
26 *Id.*
27 *Id.* at ¶ 36.
28 *Id.*
29 *Id.* at ¶ 37.
30 *Id.*
31 *Id.* at ¶ 38.
32 *Id.*
33 *Id.*
34 *Id.* at ¶ 39.
35 *Id.* at ¶¶ 40-42.
36 Memorandum Of Law In Support of Defendants' Motion to Dismiss, Civil Action No. 11-2325 (S.D.N.Y. Sept. 22, 2014), Doc. No. 55.
37 *Id.* at pp. 1-2 (emphasis in original).
38 *Id.* at p. 9 (emphasis and alteration in original).
39 *Id.* (emphasis in original).
40 *Id.*
41 *Id.* at pp. 10-11.
42 *Id.* at p. 11.
43 *Id.*
44 *Id.* at p. 14.
45 *Id.* (citing Black's Law Dictionary 327-28 (9th ed. 2009)).
46 *Id.* at pp. 14-15.
47 Doc. 59 at p. 2.
48 *Id.*
49 *Id.* at p. 3-4.
50 *Id.*
51 77 Fed. Reg. at 9182.
52 *Id.*
53 *Id.*
54 42 C.F.R. § 422.326(a)(c).
55 *Id.*

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