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COMMENTARY

U.S. District Court Issues Ruling on Preliminary Motion to Dismiss Interpreting 60-Day Overpayment Rule

Holds Identification Occurs when Providers Are "Put on Notice" of Potential Overpayment

Compliance with the labyrinth of health care rules and regulations has always been a burdensome challenge for health care providers, and particularly compliance officers who are frequently presented with potential overpayments that after months of investigation fail to reveal an actual overpayment. The United States District Court for the Southern District of New York has not made this task any easier. Instead, in a decision of first impression and in the absence of a final Centers for Medicare and Medicaid Services ("CMS") rule, the District Court in United States ex rel. Kane v. HealthFirst adopted the Department of Justice's position on the meaning of "identified" for the purpose of reporting and returning overpayments under the Affordable Care Act's ("ACA") 60-day rule.[1] In so doing, the District Court held that "the sixty day clock begins ticking when a provider is ***put on notice*** of a potential overpayment."[2]

Although the court acknowledges that its holding creates a "demanding standard of compliance in particular cases, especially in light of the penalties and damages available under the FCA," it notes that the ACA "contains no language to temper or qualify this unforgiving rule."[3] The court further provides that the government is "nowhere require[d] to grant more leeway or more time to a provider who fails to timely return an overpayment but acts with reasonable diligence in an attempt to do so."[4] In adopting the government's "stringent" interpretation that, according to the court, will in certain cases create a "potentially unworkable burden on providers," the court noted that the defendants' interpretation—which proposed a "classified with certainty" standard—would produce absurd results, including "a perverse incentive to delay learning the amount due and relegating the sixty-day period to merely the time within which they would have to cut the check."[5]

Despite the significant implications of the court's decision for compliance departments, the court provided a glimmer of light by also holding that while the "identified" overpayments might qualify as an "obligation" under the False Claims Act ("FCA"), "the mere existence of an 'obligation' does not itself establish

a violation of the FCA." The court noted that the government must still prove that the provider knowingly, as that term is defined in the FCA, concealed or knowingly and improperly avoided its obligation to return the overpayment.[6]

Factual Background and Procedural History

The New York Southern District Court's August 5, 2015 Order arose from the filing of a motion to dismiss by the defendants. Under the applicable rules, the court was required to construe the facts in the light most favorable to the government. The facts, as reported by the court, revealed that the case stemmed from overpayments that allegedly arose from a software glitch in the billing system of HealthFirst, a Medicaid managed care insurer.[7] The glitch resulted in coding that allowed the providers to seek further payment on "Covered Services" from additional payors. In reality, these "Covered Services" were included in the monthly capitation payment paid by the New York State Department of Health ("DOH") to HealthFirst, and in fact, the HealthFirst contract prohibited providers from seeking further reimbursement.[8] According to the government's complaint, the defendant health care providers allegedly submitted claims to DOH seeking further payment on the Covered Services, which were then mistakenly paid by DOH.[9]

The potential overpayments were initially brought to the attention of Continuum Health Partners by the state comptroller in September 2010.[10] The relator, Robert Kane, an employee of defendant Continuum Health Partners, was tasked with reviewing Continuum's billing data to identify the universe of claims potentially affected by the software glitch. In February 2011, after reviewing the billing data, Kane sent an email to Continuum management along with a spreadsheet containing a universe of 900 claims containing the erroneous billing code, all of which were Medicaid claims.[11] The email stated that "further analysis" would have to be conducted to confirm Kane's findings.[12] Kane was terminated five days after sending the email. Although it was later determined that only approximately half of the claims on the relator's spreadsheet constituted actual overpayments, the overpayments, according to the government's complaint, were not fully returned for two years and only after the issuance of a Civil Investigative Demand ("CID").[13]

Kane filed his initial complaint against HealthFirst on April 5, 2011, alleging violations of the FCA and the New York State False Claims Act, which was subsequently amended on May 15, 2014, for an alleged failure to timely report and return overpayments received from Medicaid related to the Covered Services. In June 2012, the government issued a CID to Continuum requesting information about the claims submitted for Covered Services rendered to HealthFirst Medicaid enrollees.[14] Both the United States Attorney's Office for the Southern District of New York and the State Office of the Attorney General, Medicaid Fraud Control Unit intervened by filing Notices of Election to Intervene in Part and Complaints-in-Intervention on June 27, 2014.[15] The United States alleged that the defendants violated the FCA's "reverse false claims" provision found at 31 U.S.C. § 3729(a)(1)(G).[16] New York also asserted that the defendants violated the similar reverse false claims provision contained in the New York State False Claims Act.[17]

The defendants filed a motion to dismiss both Intervenor-Complaints under Federal Rule of Civil Procedure 9(b) on the basis that the Complaints failed to allege that the defendants (i) had an obligation, (ii) knowingly concealed or knowingly and improperly avoided or decreased an obligation, and (iii) had an obligation to pay or transmit money to the federal government. In denying the defendants' motion to dismiss, the court engaged in an exhaustive review of statutory interpretation principles.[18]

District Court's Analysis

The primary issue before the court was whether the defendants' failure to return the identified overpayments within 60 days of such identification constituted an "obligation" to pay or transmit money to the government, thereby creating FCA liability. Thus, as an initial matter, the court was required to define the term "identified" for the purpose of determining when the 60-day clock began to tick. The government argued that the relator's email and accompanying spreadsheet identified overpayments under the ACA that matured into obligations that, when not reported and returned in 60 days of the email, constituted a violation of the FCA.[19] The defendants argued that the relator's email "only provided notice of potential overpayments and did not identify actual

overpayments so as to trigger the ACA's sixty-day report and return clock."[20] According to the District Court, the defendants urged the court "to adopt a definition of 'identified' that means 'classified with certainty.'"[21] The government, on the other hand, urged a definition that would be satisfied when "a person is put on notice that a certain claim may have been overpaid."[22] The court noted that the government's proposal would treat "identified" as synonymous with "known" as that term is defined in the FCA.[23]

The court engaged in an exhaustive review of statutory interpretation principles, including the plain meaning of the word "identify" and canons of statutory construction to include the legislative history behind the ACA's deliberate use of the word "identified" rather than use of the word "known," the necessity to "avoid absurdity," the legislative purpose behind the 2009 amendments to the FCA with the passage of the Fraud Enforcement and Recovery Act ("FERA"), and agency deference to CMS's interpretation of the ACA's report and return provisions with respect to the Part C Medicare Advantage program and the Part D Prescription Drug program.[24]

The court found that dictionary definitions failed to provide a "plain meaning" to the term "identified" as used in the ACA. Turning to the canons of statutory construction, the court found the legislative history behind Congress's choice of the word "'identified' as opposed to 'known,' a term that is expressly defined elsewhere in the ACA report and return provision," significant.[25] However, the court found it equally plausible that Congress's inclusion of the definitions of "knowing" and "knowingly" within the ACA's report and return provision "indicat[ed] that the FCA's knowledge standard should apply to the determination of when an overpayment is deemed 'identified.'"[26] The court ultimately concluded that the "put on notice" position argued by government, "rather than the moment when an overpayment is conclusively ascertained," was more compatible with the legislative history of the FCA and the FERA. In particular, the court was persuaded by FERA's definition of "obligation" as "an established duty, *whether or not fixed*, arising … from the retention of an overpayment."[27] Thus, the court concluded that allowing the defendants to evade FCA liability because the relator's email "did not conclusively establish each erroneous claim" and the specific amount owed would "contradict Congress' intentions as expressed during the passage of the FERA."[28]

Although recognizing the "demanding standard of compliance" that would be created under the court's holding, the court offered little comfort, stating that the ACA contained "no language to temper or qualify this unforgiving rule" and further finding that the ACA "nowhere requires the Government to grant more leeway or more time to a provider who fails timely to return an overpayment but acts with reasonable diligence in an attempt to do so."[29] The only glimmer of reprieve offered by the court was found in its holding that the "mere existence of an 'obligation' does not establish a violation of the FCA. Rather, … it is only when an obligation is *knowingly concealed or knowingly and improperly avoided or decreased* that a provider has violated the FCA."[30] The court went on to suggest that "prosecutorial discretion would counsel against the institution of enforcement actions aimed at well-intentioned healthcare providers working with reasonable haste to address erroneous overpayments" as such actions "would be inconsistent with the spirit of the law and would be unlikely to succeed."[31]

Despite what it referred to as a "potentially unworkable" burden on providers, the court found that the defendants' interpretation would make it impossible to enforce the reverse false claims provisions of the FCA.[32] The court's position appears to have been influenced by the facts of this case and more particularly what it found to be a likely outcome of an alternative holding, i.e., the ability of a provider "to escape FCA liability by simply ignoring the analysis altogether and putting its head in the sand [thereby] subvert[ing] Congress' intent in amending §3729(a)(1)(G)."[33] According to the court, if Kane's email were deemed insufficient to "identify" overpayments, there would be "no recourse for the Government when providers behave as Continuum allegedly behaved here. It would be an absurd result to construe this robust anti-fraud scheme as permitting willful ignorance to delay the formation of an obligation to repay the government money that it is due."[34]

The court also found that the relatively short deadline for reporting and returning overpayments, violations of which expose the provider to severe risks under the FCA, intentionally placed the onus on providers, rather than the government.[35] This reading, according to the court, was in line with the legislative purpose of the FCA as evidenced by the 1986 FCA Amendments and FERA.[36] One hopeful note was sounded in the court's consideration of CMS's interpretation

of the ACA's "report and return" provisions with respect to Part C and Part D of the Medicare programs.[37] In CMS's final rule, it explained that "reasonable diligence might require an investigation conducted in good faith and in a timely manner by qualified individuals in response to credible information of a potential overpayment."[38] The court also considered CMS's proposed rule for Medicare providers and suppliers in which CMS explained that its definition of "knowing" would give providers "an incentive to exercise reasonable diligence to determine whether an overpayment exists."[39] Failure to exercise such diligence with "all deliberate speed" could, according to CMS's proposed rule, result in the knowing retention of an overpayment under the reckless disregard or deliberate ignorance standard.[40] The court concluded by "observing" that its conclusion was "at least consistent" with CMS's interpretation of the provisions at issue in the court's decision.[41]

Compliance Takeaways

The court clearly outlined that providers cannot stick their heads in the sand when it comes to the prompt investigation of employee, or even outside, notices of potential overpayments. There is also no question that once a provider is "put on notice of a potential overpayment," the provider should exercise reasonable diligence in investigating the notice's credibility. This is consistent with the position CMS has taken with the "report and return provisions" but, as evidenced in the reasons articulated by CMS in delaying the finalization of its proposed rule for Medicare providers, there are "significant policy and operational issues that need to be resolved." Moreover, CMS's publications concerning the report and return provisions expressly acknowledge that providers need time to investigate potential overpayment allegations. Indeed, CMS's commentary to the proposed rule implies, consistent with the Court's caution to potentially overzealous prosecutors, that FCA liability results only when a provider "fails to make any reasonable inquiry" into the potential overpayment allegation.

Health care providers would also be well served to closely monitor all external audits to ensure that once specific claims that could contain overpayments are identified, follow-up investigations are conducted in a manner that allows the provider to quickly quantify actual overpayments. Perhaps even more importantly, once a provider begins an investigation, the provider must be equally diligent in returning the overpayment. Large health care providers, who may have multiple investigations proceeding at any one time, will likely be forced to prioritize resources to ensure that all investigations are being conducted in a manner that demonstrates the "reasonable haste" described by the court or at the very least, the "reasonable diligence" proposed by CMS.

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Endnotes

1 *Kane ex rel. United States v. HealthFirst, Inc.*, 11-cv-2325, 2015 U.S. Dist. LEXIS 10178 (S.D.N.Y Aug. 3, 2015).

2 *Id.* at *38.

3 *Id.* at *42.

4 *Id.*

5 *Id.* at *44, *45.

6 *Id.* at *42-43.

7 *See id.* at *3.

8 *See id.* at *5-6.

9 *See id.* at *8.

10 *See id.*

11 *See id.* at *9.

12 *See id.*

13 *See id.* at *11.

14 *See id.* at *12.

15 *See id.* at *13.

16 *See id.* at *13.

17 *See id.* at *13.

18 *See id.* at *25.

19 *See id.*

20 *Id.* at *26.

21 *Id.* at *26-27.

22 *Id.* at *27.

23 *Id.*

24 *See id.* at *27-52.

25 *See id.* at *37.

26 *See id.*

27 *See id.* at *38.

28 *Id.*

29 *Id.* at *42.

30 *Id.* at *42-43.

31 *Id.* at *43.

32 *Id.* at *45.

33 *Id.* at *43-44.

34 *Id.* at *44.

35 *See id.* at *47-48.

36 *See id.*

37 *See id.* at *49.

38 *Id.*

39 *Id.* at *51.

40 *Id.*

41 *Id.* at *52.