UP THE CREEK WITHOUT A REGULATION

by David B. Honig and Brian C. Betner

CMS ANNOUNCES FURTHER DELAY OF REPAYMENT RULE

To be published in the February 17, 2015 Federal Register, CMS has extended its deadline for finalizing the Affordable Care Act's ("ACA") 60-day payback rule. This is the rule that requires a Medicare or Medicaid provider to return an identified overpayment within 60 days of its identification. On day 61, the overpayment becomes a violation of the False Claims Act ("FCA").

The 60-day rule, found in the ACA{{1}}, as well as amendments to the FCA, are the fund-raising and enforcement tools of the new law. Together, they create an entirely new type of false claim, one that is not knowingly false when submitted but only becomes "knowingly false" once identified and not repaid within a specified time. The ramifications of this change are enormous.

CMS has yet to provide a final rule giving guidance to contractors. Significant questions remain, including basic issues such as "what qualifies as an overpayment?" and "when does a provider know of an overpayment?"

Under the proposed rule{{2}}, a provider needing time beyond the 60 days to complete a repayment may use the Extended Repayment Schedule process found in CMS's Financial Management Manual{{3}}. Until the rule is final, though, providers may rely only upon the plain language of the statute, which offers no opportunity for an extension, even using the protocol established by CMS.

Specific types of providers await a final rule to explain how the new 60-day payback requirement applies to them. Disproportionate Share Hospitals get some clarification in the proposed rule about when they must perform reconciliation, but there is no such clarification in the statute. The same section of the proposed rule provides clarification for outlier reconciliation, though there is nothing about it in the statute.

Another significant question, which remains unanswered absent of a final rule, is the applicable look-back period. The statute states that an identified overpayment becomes an FCA violation if not repaid within 60 days. It does not, though, identify a limit to the look-back period beyond which a provider has a repayment obligation. As written, the statute would require an institutional provider identifying an overpayment from decades past to research it and repay it within 60 days. If a provider fails to do so, on the 61st day it becomes a FCA violation, triggering the FCA's statute of limitations, which can stretch back as much as 10 years. Every claim, whether found on a hospital's new computer system or in a moldering carton in the back of a physician's rented storage space, could be a potential false claim. The proposed rule would limit the look-back period to 10 years, extending the FCA's effective statute of limitations back more than 20 years{{4}}.

While the government is granting itself another year to finalize the rules for the application of the new statute, there is no similar relief to providers. The government is already intervening in and actively prosecuting retained overpayment cases. The statute, the government argues, is sufficiently clear that providers can be held liable for its violation, often to the tune of millions of dollars. But the government does concede that additional time is appropriate due to "the complexity of the rule."

This must be of significant concern to providers. The government has already intervened in retained overpayment cases, including US v. Continuum Health Partners in the Southern District of New York. Whistleblowers are bringing these actions, comforted with the knowledge that providers are crippled by CMS's own failure to finalize rules that clarify their duties and define their rights and obligations. One court even allowed a case to go forward on a retained overpayment claim where no overpayment was identified because the provider's actions in changing its auditing processes were sufficient to raise a factual issue whether it did so to remain willfully ignorant of prior billing errors{{5}}.

In 2014, the government recovered almost $6 billion in FCA litigation, $1 billion more than any previous year, and announced a record 700 whistleblower filings - most of which remain under seal in federal courts. Just a few months ago, the government announced that all whistleblower cases under the FCA will be reviewed by the Criminal Division of the Department of Justice ("DOJ"). And just this month, the government asked to almost double its health care fraud litigation budget, stating that additional staff was needed to handle "the increasing number of whistleblower cases" weighing down the DOJ's enforcement efforts. Every indication is that the whistleblower FCA actions that

have been unsealed are merely the tip of the iceberg. Many more likely remain under seal awaiting first criminal then civil review. A large percentage of these are likely retained overpayment claims, which are accusations of fraud against health care providers for failing to follow rules not yet written by the government.

Until the rule is finalized, providers will be bound by the very broad and unforgiving language of the statute.

HEALTH CARE TAKEAWAY

The retained overpayment false claim is the newest and biggest tool that the government wields in its effort to rein in the costs of its health care programs. Yet there remain no rules or guidance on how, when or where that hammer can be used. A broad statute, increased government enforcement through both the civil and the criminal divisions of the DOJ and an army of avaricious whistleblowers and their attorneys creates a daunting environment for health care providers.

When attempting to traverse this challenging landscape, providers should carefully consider the following:

- First, normal compliance activities must be undertaken with additional care and with full appreciation that any errors discovered must be handled quickly with repayment in every case, no matter how small or inconsequential it may seem.
- Conversely, normal compliance activities must continue, lest the government or a whistleblower allege a change indicates a willful refusal to identify overpayments, another violation of the FCA, after 60 days.
- Third, providers may not simply rely upon their usual channels and procedure if those have not fully integrated all aspects of the retained overpayment FCA liability.
- Finally, the assistance of qualified health care counsel is more important than ever. The penalties of the FCA can reach $11,000 per retained overpayment, treble damages and even program exclusion. These risks warrant guidance in matters that might previously have been treated as day-to-day internal matters. Involving health care counsel to advise the provider at the initial stages of tackling potential overpayments is the single most important step to ensuring an effective and efficient review.

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[[1]] 42 U.S.C. 1320a-7k(d)

(2) Deadline for reporting and returning overpayments - An overpayment must be reported and returned under paragraph (1) by the later of (A) the date which is 60 days after the date on which the overpayment was identified; or (B) the date any corresponding cost report is due, if applicable.

(3) Enforcement - Any overpayment retained by a person after the deadline for reporting and returning the overpayment under paragraph (2) is an obligation (as defined in section 3729(b)(3) of title 31) for purposes of section 3729 of such title.[[1]]

[[2]] 42 CFR Parts 401 and 405, Vol. 77, No. 32, Feb. 16, 2012.[[2]]

[[3]] Financial Management Manual, Publication 100-06, Chapter 4.[[3]]

[[4]] Previously addressed here in A Twenty Year Statute of Limitations?[[4]]

[[5]] United States ex rel. Keltner v. Lakeshore Medical Clinic, Ltd., previously discussed in our April, 2013 False Claims Act Update.[[5]]