THE 60-DAY VULTURE COMES HOME TO ROOST

In a judicial opinion certain to rock the provider world, Judge Edgardo Ramos of the Federal District Court for the Southern District of New York denied a New York Health System's ("Health System") motion to dismiss the U.S.'s and New York State's complaints in intervention under the federal False Claims Act ("FCA") and state counterpart, holding that requiring the return within 60 days of a "potential" Medicare/Medicaid overpayment before it is "conclusively ascertained" is compatible with the legislative history of the FCA and the Fraud Enforcement and Recovery Act of 2009 ("FERA"). Accordingly, the case{{1}} will proceed to the discovery phase.

FACTS

Three New York hospitals ("Hospitals") were members of the Healthfirst hospital network and provided care to many patients enrolled in Healthfirst's Medicaid managed care plan. Under a contract between the New York State Department of Health ("DOH") and Healthfirst, Healthfirst provided hospital and physician services ("Covered Services") to its Medicaid-eligible enrollees for a monthly payment from DOH. All Healthfirst participants, including the Hospitals, agreed that the payment they received from Healthfirst for the Covered Services would constitute payment in full (except for applicable co-pays).

Beginning in 2009, due to a software glitch, Healthfirst's payments to participating providers, including the Hospitals, erroneously indicated vis-a-vis certain electronic codes that the participants could seek additional payment for Covered Services from secondary payors such as Medicaid or other insurance carriers. As a result, electronic billing programs used by participating providers, including the Hospitals, automatically generated and submitted claims to secondary payors including Medicaid.{{2}} In 2009, on behalf of the Hospitals, the Health System submitted claims to DOH seeking additional payment for Covered Services provided to Healthfirst enrollees, and DOH mistakenly paid the Hospitals for many of these improper claims.

In 2010, auditors from the New York State Comptroller's office ("Comptroller") questioned the Health System regarding incorrect billing. After the discovery of the billing errors, the Health System directed its employee and the whistleblower in this case to determine which claims had been improperly billed to Medicaid. In early 2011, about five months after the Comptroller alerted the Health System about the billing errors, the whistleblower emailed the Health System's management a spreadsheet detailing more than 900 claims totaling over $1,000,000 that the whistleblower had identified as containing an erroneous billing code. In the email, he stated that "further analysis would be needed to confirm his findings" and that the spreadsheet gave "some insight to the magnitude of the issue." There was no issue of material fact that the whistleblower's spreadsheet was inaccurate as roughly half of the claims listed never were actually overpaid. Shortly after the whistleblower sent his email, he was terminated. The whistleblower filed a qui tam suit under the FCA and under state false claims act statutes in April, 2011. The U.S. and New York State intervened asserting violations of federal and state FCA reverse false claims provisions (i.e., retention of an overpayment).

According to the federal government and the State of New York, the Health System "'did nothing further'" with the whistleblower's analysis or the claims he identified. In the same month (February 2011) as the whistleblower's termination, the Health System reimbursed DOH for five improperly submitted claims. Then in a period spanning April 2011 through March 2013, the Health System reimbursed DOH for the remainder of the improperly billed claims.

The United States and New York allege that the Health System "fraudulently delay[ed] its repayments for up to two years after the Health System knew of the extent of the overpayments." Further, the Health System did not repay DOH over 300 of the affected claims until June 2012, when the government issued a civil investigative demand. Therefore, by "intentionally or recklessly" failing to take the necessary steps to identify the claims affected by the Healthfirst software glitch, or timely reimbursing DOH for the overbilling, the Health System violated the federal and New York FCAs and, in particular, the Affordable Care Act's ("ACA") 60-day repayment rule, which requires a provider to report and repay any overpayments to the federal or state government within 60 days of the "date on which the overpayment was identified."

The Health System filed a motion to dismiss the case under FRCP Rule 12(b)(6) and under FRCP Rule 9(b) requiring a statement supporting "fraud with particularity." The Health System argued that the U.S.'s Complaint in Intervention could not meet the high bar established by

Rule 9(b) in part because it failed to allege that the Health System had an "obligation" under the FCA.

The central question in the case is whether the whistleblower's email and spreadsheet cataloging the alleged overpaid claims (many of which turned out not to be overpayments) properly "identified" overpayments within the meaning of the ACA and whether those overpayments matured into obligations in violation of the FCA when they were not reported and repaid within 60 days. The ACA did not define the term "identify" in the Statute and CMS, to date, has not finalized the 60-day repayment rule, which, when finalized, most certainly will define the term at issue.

The Health System argued that the whistleblower's email only provided notice of potential overpayment and did not identify actual overpayments so as to trigger the ACA's 60-day report and return clock. The government proposed that a provider has "identified an overpayment" when it "determined or should have determined through the exercise of reasonable diligence that it has received an overpayment." This is the first case to interpret the crucial undefined language in the ACA.

COURT'S ANALYSIS

Judge Ramos's decision not to dismiss the complaint in intervention hinged on the definition of the term "identified." He applied the canons of statutory construction{{3}} to reach his conclusion that the Health System's failure to act quickly enough to report and return overpayments, could well have fallen outside the 60-day return and repayment rule as well as the language and intentions of the FCA, the FERA and the ACA. He wrote:

To define "identified" such that the sixty day clock begins ticking when a provider is put on notice of a potential overpayment, rather than the moment when an overpayment is conclusively ascertained, is compatible with the legislative history of the FCA and the FERA highlighted by the Government. . . Congress intended for FCA liability to attach in circumstances where, as here, there is an established duty to pay money to the government, even if the precise amount due has yet to be determined. [emphasis added]. Here, after the Comptroller alerted Defendants to the software glitch and approached them with specific wrongful claims, and after [the whistleblower] 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. To allow Defendants to evade liability because [the whistleblower's] email did not conclusively establish each erroneous claim and did not provide the specific amount owed to the Government would contradict Congress's intentions as expressed during the passage of the FERA.

Judge Ramos also noted that the Health System's interpretation of the 60-day return and repayment rule would make it "all but impossible to enforce the reverse false claims provision of the FCA" in the health care fraud context. He quoted the government as saying, "[p]ermitting a healthcare provider that requests and receives an analysis showing over 900 likely overpayments to escape FCA liability by simply ignoring the analysis altogether and putting its head in the sand would subvert Congress's intent."

In a nod of empathy for the universe of potential defendants in FCA qui tam cases and the difficulty of doing all the work that must be done to establish the existence of an overpayment in under 60 days, Judge Ramos suggested that prosecutors will exercise discretion in pursuing enforcement actions against well-intentioned providers working with "reasonable haste" to address overpayments. This may not reassure providers faced with the discovery of possible overpayments and the prospect of would-be whistleblowers.

PRACTICAL TAKEAWAYS

1. This opinion is the first and only judicial opinion interpreting the ACA's 60-day report and return rule term "to identify." It is only binding on the Southern District of New York, but it is likely that other jurisdictions will reference and consult this case for guidance in interpreting other potential FCA situations.

2. At least until the case law is better developed and CMS issues a final rule defining what it means to identify an overpayment, providers should act with all reasonable haste when they are notified of the existence of even a potential overpayment.

3. Providers should reassess their normal compliance protocols in analyzing potential overpayments and making any necessary refunds. Providers may need to consider revamping these internal processes for compliance with this new standard.

4. Providers should further recognize that under this reasoning of the court, they may need to set the 60-day alarm even where there is incomplete and underdeveloped evidence of an overpayment.

5. Hopefully, the Court's opinion will serve as the impetus for CMS to finally issue a final rule on this subject to satisfactorily address the

many challenging questions this ruling raises for providers only trying to do the right thing when potential overpayments are brought to their attention.

6. Finally, when faced with any potential overpayment situation, providers should work with their experienced compliance counsel to consider the best response and management plan that will take into account the complexity of the situation and the risks of different action plans. Particularly complex situations may in certain circumstances call for placing allegations of billing errors under the protection of the attorney-client privilege to provide enough time to reach a conclusion on the overpayment issue.

If you have any questions or would like additional information about this topic, please contact:

- Adele Merenstein at (317) 752-4427 or amerenst@hallrender.com
- David B. Honig at (317) 977-1447 or dhonig@hallrender.com
- Scott W. Taebel at (414) 721-0445 or staebel@hallrender.com or
- Your regular Hall Render attorney.

Please visit the Hall Render Blog at http://blogs.hallrender.com/ or click here to sign up to receive Hall Render alerts on topics related to health care law._____[[1]]U.S. ex rel Kane v. Healthfirst, Inc., et al., No. 1:11-cv-02325-ER (S.D.N.Y) (Aug. 3, 2015).[[1]][[2]]Roughly two years after the parties discovered the electronic billing error, the software vendor issued a software patch to correct the glitch.[[2]][[3]]The Judge considered the following canons: 1) Consider legislative history when interpreting an ambiguous statute; 2) ambiguous statutes should be interpreted in the manner best-suited to carry out their statutory purposes; 3) interpret to avoid absurd results; and 4) offer some deference to agency interpretation of ambiguous statutes.[[3]]