END OF THE 60-DAY REFUND ROAD FOR ONE NEW YORK HOSPITAL SYSTEM

EXECUTIVE SUMMARY

On August 23, 2016, three New York hospitals (the "Hospitals") and a New York health system, which operated and coordinated a nonprofit network that included the Hospitals (collectively, the "Health System"), entered into settlement agreements (the "Settlement") for approximately $3 million with the United States and the State of New York. The Settlement resolves a False Claims Act ("FCA") suit (the "FCA Action")[1] brought based upon the "retained overpayment" theory first created in the Fraud Enforcement and Recovery Act of 2009 ("FERA") and clarified in the Affordable Care Act of 2010 ("ACA").

We previously issued a client bulletin addressing this FCA Action in 2015, when Judge Ramos of the Federal District Court for the Southern District of New York (the "Trial Court") denied the Health System's motion to dismiss the government's complaints, 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 FERA. We further addressed this issue in February 2016 when the Centers for Medicare & Medicaid Services ("CMS") issued a long-awaited final rule (the "Final Rule"), which generally clarified that an overpayment has not been "identified" under the 60-Day Rule (as defined below) until a provider has or should have, through "reasonable diligence," quantified the overpayment. This article will explore the Settlement and the underlying rulings, new developments in CMS's guidance concerning the 60-Day Rule and updated strategies for health care providers to avoid liability under this new FCA theory.

RETAINED OVERPAYMENTS AND THE FALSE CLAIMS ACT

"Retained overpayment false claims," sometimes called "reverse false claims," are a new type of FCA violation created to use the punitive power of the FCA to force repayment of unintentionally billed or paid claims once the error is discovered.

Prior to the passage of FERA, claims could only be the subject of FCA suits if they were knowingly false at the time they were submitted to a government payor. After the passage of FERA and the ACA, though, an overpayment becomes a "false claim" if not repaid within 60 days of identification (the "60-Day Rule"). FERA added additional qualifications to the definition of an FCA violation, thereby giving rise to the new 60-Day Rule, plainly stated as:

Upon identification of an overpayment from a government payor, the recipient must repay the money within 60 days. If the money is not repaid within 60 days, on the 61st day that failure becomes a false claim, as defined in the FCA.

Unfortunately, Congress did not define the term "identification" in FERA or the ACA. That left the government, whistleblowers and, most importantly, providers wondering exactly when a potential overpayment would be considered identified. Providers suggested that an overpayment was not identified until it had been explicitly verified as an overpayment with the exact amount owed determined. Whistleblowers, at the other end of the spectrum, suggested that an overpayment was identified at the first indication there might be a problem if that indication was sufficient to set a diligent provider along the path of discovering the specifics of the overpayment.

The debate came to a head in the presently discussed FCA Action when the United States and New York intervened in a whistleblower lawsuit.

THE FACTS

Healthfirst, a private, nonprofit insurance program, had a software "glitch" that caused the Hospitals to submit incorrect Medicaid claims. The erroneous remittances were first submitted in the beginning of 2009. At the time the claims were submitted, neither Healthfirst nor the Health System knew of the error. No knowingly false claims were submitted to Medicaid, and prior to 2009, none of the claims could have provided the basis for an FCA lawsuit.

In September 2010, the New York State Comptroller's office contacted the Health System about the billing. The Comptroller, the Health System and Healthfirst ultimately discovered the glitch, and in December 2010, the software was corrected. When the error was discovered, the Health System tasked Robert Kane, who would ultimately become the whistleblower in the FCA Action, with identifying any erroneous Medicaid claims submitted because of the glitch.

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On February 4, 2011, five months after the Comptroller first contacted the Health System, Kane sent an email to the Health System management preliminarily identifying more than 900 claims, resulting in more than $1 million of reimbursement from Medicaid, which may have been submitted by the Hospitals in error resulting from Healthfirst's software glitch. His email stated the errors needed to be confirmed, and in fact, approximately half of the claims identified were not erroneous. Mr. Kane was terminated four days after he sent this email. On April 5, 2011, before all the overpayments had been reimbursed, Kane filed the FCA Action under seal.

According to the federal government and the State of New York, the Hospitals "'did nothing further'" with Kane's analysis or the claims he identified. In the same month (February 2011) as Kane's termination, the Hospitals reimbursed the New York Department of Health for five improperly submitted claims. Then, in a period spanning almost two years from April 2011 through March 2013, the Health System reimbursed the New York Department of Health for the remainder of the improperly billed claims. Much of the reimbursement occurred only after the government issued a civil investigative demand asking for additional information about the overpayments.

On June 27, 2014, the United States and the State of New York filed their complaints-in-intervention, updating the allegations to include the two-year delay between Kane's original email and the completion of reimbursement. The Complaint alleged that the Health System and the Hospitals violated the FCA by failing to repay the erroneous claims within 60 days of receiving Kane's email.

DEFINING "IDENTIFIED"

The Health System moved to dismiss the action, arguing that the Kane email "only provided notice of potential overpayments and did not identify actual overpayments so as to trigger the sixty-day clock." The government responded that the Kane email "identified" an overpayment because it "determined, or should have determined through the exercise of reasonable diligence," that there was an overpayment to identify. In effect, the government asked the court to interpret "identified" as synonymous with the definition of "known" as defined in the FCA. As the trial court stated, the term "identified" was not defined in the ACA, and the question "present(ed) a novel question of statutory interpretation."

Looking at the legislative history, including the intent behind the FERA and ACA amendments to the FCA, the trial court concluded that an overpayment was "identified" so as to start the 60-day clock "when a provider is put on notice of a potential overpayment." The court went on to state that FCA liability would attach "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." While the court agreed with the government's more expansive definition of "identify," it also took efforts to note the limits of the holding, stating that "the mere existence of an 'obligation' does not establish a violation of the FCA." Instead, a provider must also have "knowingly concealed or knowingly and improperly avoided or decreased" an obligation for a violation to occur in the context of reverse false claims.

Applying this standard, the trial court found that the Hospitals' failure to act quickly enough to report and return overpayments could well have fallen outside the 60-Day Rule as well as the language and intentions of the FCA as amended by the FERA and the ACA. Accordingly, the trial court denied the Hospitals' motion to dismiss in October 2015. Notably, however, the trial court stated that despite the fact that the Health System was technically "put on notice" five months before, it was only after Kane had put the Health System on notice of a set of claims likely to contain numerous overpayments that the Health System had an established duty to report and refund money.

Interestingly, in February 2016, a few months after the trial court denied the Health System's motion to dismiss, CMS finally issued a new Final Rule (42 C.F.R. § 401.305) that adopted a more provider-friendly interpretation of "identified." Generally speaking, the Final Rule interprets the 60-Day Rule as requiring a provider to refund an overpayment to the government not more than 60 days after the amount of the overpayment is quantified if the entity acted with "reasonable diligence" (that is, timely investigated and quantified the amount of the overpayment); or not more than 60 days after the entity learned that an overpayment may have occurred if the entity did not act with reasonable diligence. The Final Rule also expressed CMS's expectation that a reasonably diligent review will typically be completed within six months. Further, this Final Rule established a requirement that overpayments must be reported and returned if an entity identifies the overpayment within six years of the date the overpayment was received, thereby creating a six-year lookback period for overpayments.

Ultimately, and despite the promulgation of the Final Rule in the meantime, the Health System entered into the Settlement to avoid the risks of FCA litigation, which may include both treble damages and a penalty of $5,500 to $11,000 per claim.[2] The parties settled for almost $3 million to resolve approximately $844,000 in Medicaid overpayments. The relator in this case will receive a $354,000 share of the Settlement proceeds.

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PRACTICAL TAKEAWAYS

Kane serves notice on health care providers that any suggestion of overpayments, from general statements of problems in the billing department to identification of specific errors, must be taken seriously and must be handled as expeditiously as possible. Even under the Final Rule, providers must be diligent in responding to, and quantifying as necessary, any mention of potential overpayments.

In particular, providers should refer to the Final Rule to make sure their response to, and internal investigation regarding, any alleged overpayment is timely. Through their compliance programs, providers should work within the parameters of the rule and act with "reasonable diligence" in quantifying any alleged overpayments. Providers should also have a procedure in place to immediately involve necessary professional assistance, from auditors to attorneys, to handle alleged issues within the limited time permitted for repayment.

In addition, part of the affirmative burden on providers should include working with the concerned employee, who must always be considered a potential whistleblower, to assure the employee that the matter has been properly handled. Sometimes this can be done by showing the employee that the concerns have been taken seriously and the claims repaid. Other times, the employee might need to be shown that the concerns are erroneous and the billing proper. Outside professionals can be of assistance here, too, as they are often able to work with the concerned employee to explain to them how the bills were correct. The *Kane* decision makes it abundantly clear that failing to heed the concerns of a concerned employee, or even worse, actively retaliating against the employee for bringing their concerns forward, can lead to actions that may pique the government's interest, even if some of the overpaid claims at issue were refunded in the meantime.

If you have any questions regarding *Kane* or the high stakes nature of the overpayment refund process, please do not hesitate to contact us:

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[1] Kane v. Healthfirst, Inc., et al., No. 1:11-cv-02325 (S.D.N.Y. 2015).

[2] The DOJ published an Interim Final Rule in June 2016, which announced that it will increase the minimum per-claim penalty to $10,781 and the maximum per claim penalty to $21,563. These adjusted amounts will apply only to civil penalties assessed after August 1, 2016 whose violations occurred after November 2, 2015.

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