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CLIENT ALERT

The Clock's Running Fast: SDNY Is First to Interpret "Identification" Under the FCA's "60-Day Rule" for Government Overpayments

by George B. Breen, Stuart M. Gerson, Daniel C. Fundakowski, and Wandaly E. Fernández

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On August 3, 2015, in *United States ex rel. Kane v. Healthfirst, Inc., et al.,* No. 1:11-cv-02325 (S.D.N.Y. Aug. 3, 2015), the United States District Court for the Southern District of New York issued the first reported opinion on the False Claims Act's ("FCA's") reverse false claim overpayment provision and when an overpayment is deemed "identified" by a health care provider. Federal and state agencies intervened in the case based on a *qui tam* relator's allegations that a provider failed to report and refund an overpayment within 60 days from the time the relator identified it. The district judge denied a motion to dismiss, holding that the FCA's statutory 60-day clock for repaying "identified" overpayments begins ticking "when a provider is *put on notice of a potential overpayment*, rather than the moment when an overpayment is conclusively ascertained." This conclusion is obviously problematic when considering what often needs to be done to verify overpayments in fact.

This case is the first of its kind, and it will be perceived as a significant victory by government enforcers and *qui tam* relators who will use it as a precedent for future actions. We believe that the statute in question is improperly vague on its face and that review by federal courts of appeal at some time in the future, whether in the instant case or not, is inevitable. For the present, however, providers need to be aware of the *Kane* decision and its short-term ramifications.

I. Factual Background

The complaint alleges that, because of a software glitch, three New York City hospitals allegedly erroneously billed the New York Medicaid program as a secondary payor after already being paid in full by the patients' Medicaid managed care plan. After the State Comptroller inquired about the issue, management tasked the eventual relator with investigating. Five months later, the employee sent an email to management with a spreadsheet of more than 900 claims from the three hospitals (totaling over $1 million)

that the employee claimed were subject to the glitch. He was terminated four days later. Over the next two years, the hospitals refunded the overpayments. However, the relator and intervening governments alleged that the hospitals had fraudulently delayed repayment by taking up two years, rather than the mandated 60 days, in making repayment.

II. <u>What the "60-Day Rule" Means for Health Care Providers</u>

The Affordable Care Act ("ACA") contains a provision that imposes liability on any provider that receives an overpayment from Medicare or Medicaid and fails to repay the overpayment within 60 days of the "date on which the overpayment was *identified*." 42 U.S.C. § 1320a-7k(d)(1)(emphasis added). This so-called "60-day rule" provides that any overpayment retained beyond that term becomes an "obligation" to the federal government, which can result in liability under the FCA. The FCA provides for treble damages and civil penalties of $5,500 to $11,000 per claim. Notwithstanding the gravity of this provision, Congress did not define the term "identified" for purposes of determining when the 60-day clock begins. And that is at the heart of the problem that providers face.

III. <u>Key Takeaways for Health Care Providers</u>

The *Kane* decision presents a novel and solitary statutory interpretation that other courts are likely to grapple with. Focusing on what it believed were the operative facts, the *Kane* court found that the overpayments alleged had been "identified" at the point that the relator presented his evidence to management. Irrespective of the particulars of the case itself, this troubling conclusion is something that providers need to anticipate when allegations of potential overpayments are made.

(A) Beware of the Potential for the Government Successfully Arguing That "Notice" and "Identified" Are Congruent Terms

The *Kane* court held that "identification" of an overpayment occurs—and the 60-day clock begins—when a health care provider is "put on notice" of a potential government overpayment rather than when an overpayment is *conclusively ascertained*." Both government enforcers and relators increasingly will bring cases on this theory.

(B) It Is Imperative to Document Overpayment Investigation Response Efforts

In order to mount a defense against a knowing violation of the 60-day rule, it is critical that health care providers document and keep detailed records of what actions were taken in response to a reported overpayment and how the investigation was handled internally at each stage. A vigorous investigative response, well documented, will help demonstrate that there is no "identification" in fact while a good-faith effort to make an ultimate determination is underway.

(C) The Opinion's Lack of Clarity Calls for Vigorous Defense

The *Kane* court's view of the law creates inherent ambiguities. The court viewed the case itself as something of an outlier, the outcome of which was determined by what the court concluded were egregious facts. Hence, the court's categorical view of what it takes to be "put on notice" is problematic as to future cases. It is patently unreasonable to think that the law means that once an employee internally reports any alleged overpayment, a provider is obligated, without more, to return the amount described within 60 days. If that is the case, the statutory provision might be subject to a facial constitutional challenge as to vagueness in that this interpretation does not allow for a reasonable and meaningful investigation that likely could take a good deal more than 60 days to complete.

The 60-day rule must be held to provide leeway for reasonable diligence, and providers subject to it should have a clearly conceived and documentable plan for conducting it.

(D) "Prosecutorial Discretion" Is an Illusory Safeguard for FCA Cases

The *Kane* court suggested that the appropriate exercise of "prosecutorial discretion" would be an ameliorating antidote to the apparent rigidity and "unforgiving" nature of the 60-day rule. Given the fact that government officials are under constant political pressure to attack alleged health care fraud and *qui tam* relators are economically motivated to bring cases, this is small consolation and worthy of little reliance.

(E) Overpayment Enforcement Is Expected to Increase

With the release of this long-awaited opinion, government overpayment enforcement is expected to increase. Indeed, on the same day that *Kane* was decided, the Justice Department announced a "first of its kind" $6.88 million settlement with a nursing home services provider in a similar overpayments case, and the Department has signaled its intention to pursue similar cases with vigor.

(F) CMS Still Has Not Issued Its Final Rule on Overpayments

Although there is considerable ambiguity and uncertainty in the court's opinion, the Center for Medicare & Medicaid Services ("CMS") is expected to offer additional clarity on the issue when it releases its final rule on overpayments relating to Medicare Part A and Part B providers and suppliers. As we previously reported in this posting, on February 16, 2012, almost two years after the passage of the ACA, CMS issued a proposed rule on overpayments. Under that proposed rule, an overpayment is "identified" when a provider "has actual knowledge of the overpayment or acts in reckless disregard or deliberate ignorance of the overpayment." Thus, where a provider receives information concerning a "potential overpayment," it would have "an obligation to make a reasonable inquiry to determine whether an overpayment exists." CMS announced on February 17, 2015, that its final guidance will be delayed until at least February 2016. Providers and their trade association should consider their options for further comment and potential challenge under the Administrative Procedure Act.

(G) State Medicaid Regulations May Complicate the Application of the 60-Day Rule

For example, Massachusetts' Medicaid program, MassHealth, has an overpayments regulation that closely tracks the federal provision. According to that state, after identifying an overpayment, "[t]he provider should not send a check for any overpayment, unless the provider has received prior written approval from MassHealth. Once the full overpayment has been determined, MassHealth will initiate its standard recoupment process." Here, a provider is instructed not to repay an overpayment until the process is initiated by MassHealth—a process that might take longer than 60 days to complete—and which would technically run afoul of the FCA's overpayment provision. The *Kane* court's reasoning would be particularly anomalous in such circumstances.

Conclusion

More than five years since the passage of the ACA, we are starting to see judicial interpretation as to what it means to "identify" an overpayment under the FCA, thereby triggering the 60-day clock. Although the *Kane* court provides the first formal decision in the field, its practical guidance is questionable and its ambiguous holding may encourage an onset of meritless FCA lawsuits, which health care providers should not hesitate to vigorously defend. *Kane* surely is not the last word in the field.

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This Client Alert was authored by **George B. Breen, Stuart M. Gerson, Daniel C. Fundakowski,** *and* **Wandaly E. Fernández**. *For additional information about the issues discussed in this Client Alert, please contact one of the authors or the Epstein Becker Green attorney who regularly handles your legal matters.*

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