CARLTON FIELDS

Kane v. Healthfirst and the 60-day Repayment Rule

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Case: *Kane v.Healthfirst, Inc. et al.* and *U.S. v. Continuum Health Partners Inc. et al.*, case number1:11-cv-02325, in the U.S. District Court for the Southern District of New York. As part of the Affordable Care Act (ACA), Congress adopted the requirement that any person or entity that has received an overpayment from the federal (or a state) government must report and return the overpayment within 60 days after the date such overpayment was "identified." Failure to timely return an overpayment constitutes a "reverse false claim." The 60-day repayment rule went into effect nearly four years ago with little to no additional guidance issued on its enforcement. That ended on August 3, when the U.S. District Court for the Southern District of New York released a ruling interpreting, for the first time, the False Claims Act's (FCA) 60-day overpayment provision. **Background**
The case stems from a software glitch on the part of Healthfirst, Inc. (Healthfirst), a private, non-profit insurance program, which caused Continuum Health Partners, Inc. (a three-hospital, not for profit system in New York City) to submit improper claims seeking reimbursement from Medicaid for services rendered to beneficiaries of a managed care program administered by Healthfirst. The New York Office of the State Comptroller first raised the issue in September 2010. The Comptroller identified a small number of claims where New York Medicaid had been billed as a secondary insurer for services furnished to Healthfirst enrollees. The hospitals conducted an internal investigation and discovered in February 2011 that the software glitch may have affected many more claims than originally identified. Robert Kane, an employee working in the revenue cycle department, was asked to investigate the error and determine the scope of potential liability. According to the pleadings on file, Mr. Kane determined that potentially 900 claims representing payments exceeding $1 million may have been wrongly submitted to and paid by New York Medicaid. He sent an email to the hospitals' administrators describing the potential liability and was subsequently terminated by the hospitals. The hospitals began to make repayments to the New York Medicaid program, but instead of reimbursing the overpayments within the required 60-day period, did not ultimately complete the repayment process until March 2013. Specifically, the hospitals neglected to repay more than 300 claims until they received the government's civil investigative demand in June 2012. The government alleges that the hospitals violated the FCA's "reverse false claims" provision[1], and its New York

corollary by “intentionally or recklessly” failing to take necessary steps to timely identify claims affected by the Healthfirst software glitch or timely reimburse the government for the overbilling.[2] Pursuant to 42 U.S.C. § 1320a-7k(d), which was passed in 2010, an ACA overpayment must be reported, explained, and returned within 60 days after the date it was “identified.” Under the FCA, the government can pursue civil penalties against providers who fail to return an overpayment to the government. Those penalties include a minimum civil penalty of $5,500 per false claim and a maximum of $11,000 per false claim (roughly $10 million in the instant case), plus three times the amount of damages that the government sustains.[3] Since the ACA was passed, providers have had a very difficult time determining when the 60-day overpayment clock starts ticking. This is because Congress did not define the pivotal word “identified,” which triggers the 60-day report and return clock, in the text of the ACA. **Arguments & Ruling**

The government argued that the Mr. Kane’s email and spreadsheet properly “identified” overpayments within the meaning of the ACA, and that these overpayments matured into “obligations” in violation of the FCA when they were not reported and returned by the hospitals within 60 days. The hospitals, on the other hand, argue that Mr. Kane’s email only provided notice of “potential” overpayments and did not identify actual overpayments so as to trigger the ACA’s 60-day report and return clock. The court acknowledged that dictionary definitions alone could not decisively resolve what it means to "identify" something. As a result, the court resorted to the canons of statutory construction and looked to both the legislative history and whether either of the competing interpretations from the government and the hospitals would produce "absurd results." Upon reviewing the legislative history the court concluded that to define “identified” such that the 60-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. Specifically, the court stated: 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…To allow Defendants to evade liability because Kane’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. Moreover, in considering the legislative purpose, the court found that each time Congress has weighed in on the purpose and power of the FCA, it has endorsed a reading of that statute as a robust, remedial measure aimed at combating fraud against the federal government as firmly as possible. Therefore, according to the court, by requiring providers to self-report overpayments and imposing a relatively short deadline for repayments, violation of which risks the severe liability of the FCA, Congress intentionally placed the onus on providers, rather than on the government, to quickly address overpayments and return any wrongly collected money. In its opinion, the court also considered whether either of the competing interpretations from the government and the hospitals would produce "absurd results," and rejected the hospitals’ argument that to require reporting and returning within 60 days of the identification of “potential” overpayments would impose an unworkable burden on healthcare provider. Rather, the court stated: [P]rosecutorial discretion would counsel against the institution of enforcement actions

aimed at well-intentioned healthcare providers working with reasonable haste to address erroneous overpayments. Such actions would be inconsistent with the spirit of the law and would be unlikely to succeed. **Effect of Ruling**

This ruling gives providers a real sense for how courts (and the Department of Justice) will interpret the 60-day requirement. According to the court in this case, a mere allegation of an overpayment may trigger the start of the ACA's overpayment clock. This ruling gives more teeth to the 60-day rule, which previously had a fragmented interpretation, at best. It also provides a strong foundation for potential whistleblowers who may have been equally unsure of the real meaning behind "identification." Additionally, the Centers for Medicare & Medicaid Services (CMS) likely was waiting for the U.S. District Court for the Southern District of New York to rule on this pending motion before issuing its final regulations for the 60-day rule. Providers should anticipate that the court's ruling here likely will embolden CMS to finalize a more restrictive set of regulations addressing the 60-day rule. Ultimately, providers should continue to carefully monitor complaints, the timeliness of internal investigations regarding potential overpayments, and the credibility of the reviewers and their conclusions. The contemporaneous documentation of the processes will be critical in defending against any alleged violation of the 60-day rule. ___ [1] 31 U.S.C. § 3729(a)(1)(G)

[2] § 189(1)(h)

[3] See 31 U.S.C. § 3729; 28 U.S.C. § 2461.

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