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Court Imposes Potentially Unworkable Burden on Providers Under ACA's Report and Return Rule

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In *Kane ex rel. U.S. v. Healthfirst, Inc.*, the federal district court for the Southern District of New York (District Court or Court) provided on August 3 the first and long-awaited interpretation as to when a health care provider has "identified" an overpayment for purposes of the Affordable Care Act's (ACA) report and return requirement. Under the ACA provision, a provider must report and return a Medicare or Medicaid overpayment within 60 days after it is identified, and the failure to do so within that time constitutes a false claim subject to the False Claims Act (FCA).

The Court ultimately adopted the government's position that an overpayment is "identified" when "a provider is put on notice of a potential overpayment, rather than [at] the moment an overpayment is conclusively ascertained." Although this opinion is binding precedent only in the District Court, that court's reasoning is often followed by other district courts. The case thus presents providers everywhere with substantial risks, and therefore the need for careful scrutiny, of potential government overpayments.

Continuum Health Partners Inc. was a hospital network that participated in a Medicaid managed care plan offered by Healthfirst. A computer glitch in the translation of billing codes from Healthfirst's software to Continuum's software caused Continuum to receive payments to which it was not entitled and of which Healthfirst notified Continuum in 2009. In September 2010, the New York Comptroller's office contacted Continuum regarding the incorrect payments. Continuum then asked Robert Kane, who had been its Technical Director of Revenue Cycle Operations for Hospital Systems & Operations since 2004, to investigate the issue. Kane sent a February 2011 email to Continuum management listing approximately 900 claims that were potentially erroneously paid by Healthfirst. Continuum fired Kane five days later. Kane filed the instant *qui tam* (whistleblower) action in April 2011, in which the United States intervened. Continuum did not report and repay the overpayment, which ultimately related to only approximately 300 claims, until it received a Civil Investigation Demand from the government in June 2012.

The District Court held that Continuum was "put on notice," and therefore the overpayment was "identified," no later than February 4, 2011, when Kane sent his email following the Comptroller's notice of the software glitch. In reaching this conclusion, the Court relied upon sources such as the legislative history, a final Center for Medicare & Medicaid Services (CMS) rule governing reporting and repayment by Medicare Part C and Part D plans, and CMS's 2012 proposed rule on the application of the overpayment statute to Medicare providers (which has not been finalized).

The Court's analytical process may have been sound, and it may have reached a result with which few would disagree based on the facts presented. Yet, like the 4th Circuit's opinion in *Tuomey*, the *Kane* opinion illustrates what can happen when courts must apply highly technical legislation or regulations to egregious facts. The courts may, as in *Tuomey* and *Kane*, interpret the law in a much more expansive way than is necessary to address the facts before them. For example, the *Kane* Court need not have defined "identified" so broadly to include every instance in which "a provider is put on notice of a potential [not actual] overpayment." The Court could have instead held that a provider must undertake a timely and reasonable investigation when it receives notice of a potential overpayment, and that the 60-day clock might not begin to run until the provider timely and reasonably determines that an actual overpayment appears to exist.

The District Court apparently felt compelled by the statute to define "identified" as it did, but we submit that it could have done far less statutory damage with the above approach than it did by simply (if not simplistically) saying "prosecutorial discretion" will avoid imposition of FCA penalties when a provider moves with deliberate speed to quantify the overpayment but is unable to do so before the 60-day period expires. As with *Tuomey*, providers are thus left with little clear guidance on how more typical, less abusive facts might be analyzed. Certainly, "trust your Justice Department to do the right thing" cannot be the answer.

Despite the weaknesses of the District Court's opinion, there are at least two important points from *Kane* that hospitals and other providers should keep in mind:

(1) The overpayment statute is self-effecting and applicable to Medicare and Medicaid providers, even before CMS issues final regulations applying it to them (a position CMS took in the proposed regulations); and

(2) An overpayment that was wholly innocent (*i.e.*, not "knowing" under the FCA) when received may nevertheless result in FCA liability, if it is not reported and returned within 60 days after it is "identified."

Unless the *Kane* opinion is reversed or limited, many providers will face an intolerable position under the overpayment statute. Baker Donelson has been advising our clients in this very difficult area since the rule was enacted in the ACA.

If you have any questions regarding the definition of when an overpayment is "identified", please contact a member of our Health Law team.