PUBLICATION

Update on First 60-Day Case [Ober|Kaler]

2016

A settlement was reached on August 23, 2016, in *U.S. ex rel. Kane v. Healthfirst, Inc., et al.*, No. 11 CIV. 2325 (ER) (SDNY), a little over one year after the judge in that case issued the first judicial interpretation of the Affordable Care Act's 60-day repayment requirement in the context of a False Claims Act (FCA) case. *Kane* involved accusations that the defendants, including a managed care organization (MCO) and several hospitals, knowingly and improperly avoided or decreased an obligation to pay or transmit money or property to the government, known as “reverse false claims” under the FCA.

The relator's allegations stemmed from a computer glitch that resulted in the submission of improper claims starting in 2009. The relator, a then-employee of the MCO defendant, was asked to ascertain which claims had been improperly billed. On February 4, 2011, the relator sent an email to management listing 900 claims he had identified, along with a statement that further analysis would be needed to confirm his findings. Four days later, the relator was terminated. He filed a sealed *qui tam* on April 5, 2011 – 61 days after he sent his email identifying the 900 claims – asserting reverse false claims liability and a claim for retaliation under the FCA. Upon intervening as to the relator's reverse false claims allegations, the United States alleged that the defendants “did nothing with the set of claims [the relator] pointed out as potentially overpaid and paid back hundreds of claims only after the Government's [Civil Investigation Demand].”

On August 3, 2015, the judge denied the defendants' motion to dismiss, holding that “the date on which the overpayment was identified” occurs when a health care provider is “put on notice of possible overpayments” – in this case, the date of the relator's February 4, 2011, email. The parties then moved to stay discovery and entered into settlement negotiations, which resulted in a $2.95 million settlement to resolve allegations that the defendants knowingly retained over $844,000 in overpayments made by Medicaid in violation of the federal and New York False Claims Acts.

Ober|Kaler's Comments: Implications for the Future

On a going-forward basis, it seems unlikely that the initial decision in *Kane* or this settlement ultimately will have much influence on the 60-day requirement. CMS's final rule on the 60-day requirement, which became effective on March 14, 2016, clarifies that an overpayment is considered to be identified when a provider or supplier has or should have, through the exercise of reasonable diligence, determined that it has received an overpayment ***and*** quantified the amount of the overpayment. In other words, mere notification of the possibility of an overpayment does not start the 60-day clock ticking on the requirement to make a repayment, as the initial decision in *Kane* suggests. Instead, such notification triggers an obligation to exercise reasonable diligence. This clarification allays some of the initial concerns that arose in the wake of the *Kane* court's August 2015 opinion.