New York Court Issues First Decision Taking Hard-Line Position on Meaning of "Identified" For Purposes of Sixty Day Obligation to Repay Overpayments

James A. Robertson

John W. Kaveney

Cecylia K. Hahn

By James A. Robertson, John W. Kaveney and Cecylia K. Hahn

On August 3, 2015 the United States District Court for the Southern District of New York in Kane v. Healthfirst, Inc.[1] issued the first court decision interpreting the meaning of the word "identified" in the Patient Protection and Affordable Care Act's ("ACA") requirement that all overpayments be repaid within 60 days of being identified. While the decision discussed other legal matters, this aspect of the holding marks a significant turning point in the law as the court took a hard-line position on the definition.

Providers should take note as this decision is a sharp divergence from the practice of most providers and their counsel who have read "identified" to mean not just the identification of a potential overpayment but a full quantification of the amount at issue before the sixty day clock would begin to run. The court in Kane rejected such an interpretation. Thus, while this decision is only one case and has limited precedential impact, it is a clear blueprint of the government's position on this issue and may be just the start of future judicial and/or legislative determinations to come on the subject.

Factual Background

Kane involved a software glitch on the part of Healthfirst, Inc., which caused a New York City hospital to submit improper claims for reimbursement from Medicaid for services rendered to beneficiaries of a managed care program administered by Healthfirst. Pursuant to Healthfirst's contract with the New York State Department of Health ("DOH"), Healthfirst agreed to provide certain covered services to Medicaid eligible enrollees in exchange for a monthly payment from DOH. All providers participating in Healthfirst's network were required to agree that the payment received would constitute full payment, except for co-payments.[2]

Beginning in 2009, a software glitch at Healthfirst resulted in remittances to providers erroneously indicating that they could seek additional payment for covered services from secondary payors, including Medicaid. Consequently, electronic billing programs used by numerous providers resulted in them automatically and erroneously generating and submitting bills to Medicaid. DOH mistakenly paid many of the providers for the improper claims.[3]

In 2010, the glitch was corrected and in February 2011 an email was circulated among leadership of one provider attaching a spreadsheet of erroneous claims. The spreadsheet was admittedly overly inclusive while also including the vast majority of the erroneously billed claims. However, only limited repayments of claims occurred immediately thereafter with the majority of claims not being repaid until March 2013.[4]

Thus, the United States and New York alleged that the provider "fraudulently delay[ed] its repayments for up to two years after [the provider] knew of the extent of the overpayments."

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Moreover, it was not until the government issued a June 2012 Civil Investigative Demand seeking additional information about the provider's overpayments that the remaining affected claims were repaid. As a result, the United States and New York alleged a violation of the False Claims Act and its New York corollary stating the repayments were not made within sixty days of being "identified."[5]

The False Claims Act

The False Claims Act is meant to provide a means of enhancing "the Government's ability to recover losses sustained as a result of fraud against the Government." At issue in this case was the so-called "reverse false claim."[6] The reverse false claim provision imposes liability on any person who "knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government."[7] Knowing encompasses not only actual knowledge but also individuals who act in deliberate ignorance or reckless disregard of the truth or falsity of information. Moreover, the knowledge standard expressly requires no proof of specific intent to defraud.[8]

The Patient Protection And Affordable Care Act

In 2010 Congress passed the ACA, which among many other provisions, included a provision prohibiting retention of Government overpayments in the healthcare context. The ACA requires that a person who receives an overpayment of Medicare or Medicaid funds to "report and return" the overpayment within sixty days of the "date on which the overpayment was identified." Any overpayment retained beyond the sixty days constitutes an "obligation" carrying liability under the FCA.[9] Despite this strict deadline for repayments, the ACA failed to define the pivotal word "identified" which would start the sixty day clock to return funds. Moreover, there have been no regulations adopted to provide further guidance in the Medicaid context. Thus, the court in Kane took on the task of determining the definition of "identified" for purposes of assessing when the sixty day clock would begin to run.

Court's Legal Analysis Of Statute

The government argued that the internal email of the provider properly "identified" overpayments within the meaning of the ACA and thus the overpayments matured into obligations in violation of the FCA when they were not reported and returned within sixty days. The providers, however, argued that the email only provided notice of potential overpayments and did not identify all actual overpayments so as to trigger the ACA's sixty day reporting and repayment clock. Thus, while the providers urged a definition of "identified" as meaning "classified with certainty", the government urged a definition that would be satisfied where, as in Kane, a person is put on notice that a certain claim may have been overpaid.[10]

When addressing a question of statutory interpretation a court must first look to the plain meaning, if there is one, and where no definition for a term has been provided, then its ordinary, common-sense meaning should be applied.[11] Unfortunately, "identified" is subject to alternative plain meanings. Thus, the court in Kane was required to look to "the statutory scheme as a whole and plac[e] the particular provision within the context of that statute." The statutory scheme includes (1) a review of the legislative history, (2) a review of the manner best-suited to carry out the statutory purpose, (3) a determination of the best interpretation to avoid absurd results and (4) deference to any agency interpretation.[12]

1. Legislative History

Reviewing the legislative history, the court found that Congress intended FCA liability to attach in circumstances, such as here, where there is an established duty to pay money to the government, even if the precise amount due has yet to be determined.[13] It based this conclusion on a Senate Judiciary Committee report that reflected a long-held view of the Committee that an "obligation" under the FCA "arises across the spectrum of possibilities from the fixed amount debt obligation where all particulars are defined to the instance where there is a relationship between the Government and a person that 'results in a duty to pay the Government money, whether or not the amount owed is yet fixed.'"[14]

2. Avoidance of an Absurd Result

On the question of avoiding absurdity, the providers asserted that imposing the government's interpretation would place an unworkable burden on providers to require reporting and returning overpayments within sixty days of identifying even potential overpayments. While the court recognized that the government's interpretation can potentially impose a demanding standard of compliance in particular cases, it did not find any language in the ACA to temper or qualify the provision and thereby the court did not believe it had the authority to grant more leeway or more time to providers who fail to timely return an overpayment.[15]

However, the court did acknowledge that the mere existence of an "obligation" does not establish a violation of the FCA. Rather, an FCA violation only exists when an "obligation" is knowingly concealed or knowingly and improperly avoided or decreased. Therefore, prosecution of well-intentioned healthcare providers "working with reasonable haste to address erroneous overpayments" would be inconsistent with the spirit

of the law. In fact, the Government even conceded as such in a pre-motion conference stating: "[T]his is not a question . . . of a case where the hospital is diligently working on the claims and it's on the sixty-first day and they're still scrambling to go through their spreadsheets . . . the government wouldn't be bringing that kind of a claim."[16] In that context, the provider would not have acted with the reckless disregard, deliberate ignorance, or actual knowledge of an overpayment required to support an FCA claim.

Thus, while acknowledging some leeway in the definition, the court nevertheless accepted the Government's position as less likely to result in an absurd result.

3. Legislative Purpose

In reviewing the legislative purpose, the court found that the FCA and ACA intentionally placed the onus on providers rather than the Government to quickly and swiftly address overpayments and return any erroneously collected money. The court found that the providers' reading would frustrate the purpose of the ACA and FCA's stringent penalty scheme. Thus, it again accepted the government's position.[17]

4. Agency Interpretation

Finally, on the issue of agency interpretation, the court placed limited weight on any position of CMS given the lack of authoritative regulations on the topic.[18] However, the court did note a 2014 CMS final rule implementing the ACA's reporting and returning provision with respect to Part C and Part D programs. In that rule, CMS defined "identified overpayment" consistent with its position in the Kane case and explained that it could not adopt the commenters' request for a less stringent definition because it would permit organizations to easily avoid returning improperly received payments thereby defeating the purpose of the ACA.[19] Thus, while this rule did not technically apply in the context of Medicaid, the court held that there was no reason to assume that CMS's interpretation of "identified" would be interpreted differently in the present context.

Moreover, in February 2012, CMS issued a proposed rule for Medicare providers and suppliers with the same definition of "identified" under the adopted Medicare Part C and D rule. The proposed rule has yet to be adopted but defined an overpayment as "identified" when a provider "has actual knowledge of the overpayment or acts in reckless disregard or deliberate ignorance of the overpayment." Consequently, CMS stated that when a provider receives information concerning a "potential overpayment" the provider would have an obligation to make a reasonable inquiry and a failure to do so with "all deliberate speed . . . could result in the provider knowingly retaining an overpayment because it acted in reckless disregard or deliberate ignorance of whether or not it received such an overpayment."[20]

Consequently, while not directly applicable to Medicaid, the court found the agency interpretation consistent with its conclusions.

Conclusions

While limited in its precedential authority, the analysis in Kane could ultimately prove to be a significant decision for healthcare providers. To date most providers have operated under the position that "identified" meant identify and quantify. And, there has been limited resistance from the government on this position. However, this decision and CMS's positions in the proposed and adopted regulations for the sixty day rule suggest providers will need to become even more diligent and proactive in their audit efforts. Any delay believed by the government to fall outside a "diligent effort" could be construed as an FCA violation regardless of whether a provider is still attempting to identify the scope and amount of an overpayment.

It is expected that the Kane decision will be only the first of other decisions to follow on the subject and CMS is still in the process of finalizing regulations to define "identified." While the ultimate outcome of how "identified" will be defined is not yet fully settled, the writing is on the wall that a strict interpretation is likely to be adopted. While the analysis will ultimately be fact specific in each instance of a potential overpayment, providers must ensure their compliance programs and internal auditing efforts are robust and timely. Anything less risks a claim of knowingly retaining or recklessly disregarding an overpayment in violation of the FCA.

About the Authors

James A. Robertson is a Partner and head of the health care practice at McElroy, Deutsch, Mulvaney & Carpenter, LLP, with ten offices in New Jersey, New York, Connecticut, Massachusetts, Pennsylvania, Delaware, and Colorado. John W. Kaveney and Cecylia K. Hahn are associates in the health care practice of McElroy, Deutsch, Mulvaney & Carpenter, LLP.

Footnotes

[1]Kane v. Healthfirst, Inc., 1:11-cv-02325-ER (August 3, 2015)
[2]Id. at 3-4
[3]Id. at 3
[4]Id. at 4-6
[5]Id. at 6
[6]S. Rep. No. 99-345 at 2 (1986), reprinted in 1986 U.S.C.C.A.N. 5266
[7]31 U.S.C. § 3729(a)(7)
[8]Kane, supra, at 10.
[9]42 U.S.C. § 1320a-7k(d)
[10]Kane, supra, at 16-17
[11]Barnhart v. Sigmon Coal Co., 534 U.S. 438, 450 (2002)
[12]Kane, supra, at 19-20.
[13]Id. at 20-24
[14]S. Rep. No. 111-10, at 14 (2009), reprinted at 2009 U.S.C.C.A.N. 430, 441
[15]Kane, supra, at 24-27
[16]Id. at 26.
[17]Id. at 27-29
[18]Id. at 29
[19]79 Fed. Reg. 29,844 (May 23, 2014); 42 C.F.R. § 422.326(c), § 423.360(c)
[20]77 Fed. Reg. 9179-9187 (Feb. 16, 2012)