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Expert Analysis

Health Care Overpayments And Reverse False Claims

By
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Imagine the following. A system of hospitals learns that an insurer's mistake caused the hospitals to unwittingly overbill Medicaid. They task an employee with investigating the error. The employee emails management 900-plus claims that "may have been wrongly submitted to and paid by Medicaid." The list is over-inclusive but circulated simply to give "some insight into the magnitude of the issue." The employee then leaves the hospitals. No one takes over his project. At the same time, a regulator begins identifying affected claims and seeking repayment from the hospitals. The hospitals cooperate in an iterative process that takes two years. Medicaid is made whole.

Yet the hospitals' troubles are far from over. The departing employee waited just two months and then filed a sealed federal complaint alleging a violation of the False Claims Act. The United States and the State of New York investigated and intervened, seeking treble damages, plus millions of dollars in penalties. The U.S. Attorney called the hospitals' two-year delay in fully repaying Medicaid "fraud." The hospitals moved to dismiss the case, to no avail.

This is the fact pattern in *United States ex rel. Kane v. HealthFirst*, 11 Civ. 2324 (S.D.N.Y. Aug. 3, 2015). In *Kane*, U.S. District Judge Edgardo Ramos held that the hospitals could be liable under the False Claims Act because they did not promptly refund Medicaid after receiving the employee's email. *Kane* is the most significant case interpreting the so-called "reverse false claims" provision of the federal False Claims Act, 31 U.S.C. §3729(a)(1)(G), and the New York False Claims Act, N.Y. State Fin. Law §189(1)(h), and the first to interpret the term "identified" under the Patient Protection and Affordable Care Act of 2010 (ACA).

The ACA is a trigger for reverse false claims liability. The state and federal False Claims Acts apply, broadly, to persons or organizations that receive government funds, and provide for significant statutory penalties, treble damages, and attorney fees. The statutes are whistleblower statutes, with qui tam provisions, which allow whistleblowers (relators) to file suits on behalf of the government and to share in the government's recovery.

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The ACA contains a requirement mandating that every health-care provider report and return Medicare or Medicaid overpayments within 60 days of their identification. In *Kane*, the court found a violation of the ACA's report-and-return provision that the court deemed sufficient to violate the False Claims Act.

Reverse False Claims

The Kane decision concerns the most elusive provision of the False Claims Act, its "reverse false claims" clause. The reverse false claims provision, as recently amended, creates liability for a defendant who "knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property" to the government.[1] Reverse false claims have three key elements: (i) an obligation; (ii) concealment or improper avoidance; and (iii) knowledge.

The first element, an "obligation," "means an established duty, whether or not fixed, arising from" a contract, grant, statute, or regulation, "or from the retention of an overpayment."[2] The second element, concealment or improper avoidance, is not further defined in the statutes. The last element, knowledge, extends to "acts in deliberate ignorance" and "reckless disregard" of the truth.[3] While the last element is common to all False Claims Act provisions, the first two elements are unique to reverse false claims and have yet to be fully explicated by the courts. *Kane* tackles those elements.

ACA's 60-Day Clock

The Kane decision also addresses the report-and-return provision of the ACA, and is the first to construe it. The ACA establishes the duty to report and return overpayments of Medicare or Medicaid funds within 60 days "after the date on which the overpayment was identified."[4] The ACA unambiguously states that retention of any overpayment beyond that deadline creates an obligation under the False Claims Act.[5]

There has been great debate over when an overpayment is sufficiently "identified" to trigger the ACA's 60-day clock. *Kane* is the first decision to wade into the debate.

Government's Positions

Kane is also the first case where the Department of Justice has articulated its position on key terms under the False Claims Act and ACA. Its positions are significant because the Justice Department is likely to stick to them in other cases.

In *Kane*, the United States pressed a broad definition of "obligation." It argued that the court did not need to interpret the ACA report-and-return provision because the False Claims Act imposes an obligation to refund "all types of overpayments," not just Medicare or Medicaid overpayments. Every overpayment, it reasoned, triggers an "obligation." Under this logic, the hospitals had an "obligation" as soon as they had an overpayment.

The United States declined to define, with any precision, the term "identified" as used in the ACA. The hospitals argued that identification required

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evidence of actual knowledge that a particular payment was an overpayment. The government rejected this view, arguing that the hospitals had "identified" overpayments under the ACA as soon as they received the list of potentially affected claims. Yet the government did not explain its conclusion by articulating any test for when an overpayment has been sufficiently "identified" to trigger report-and-return obligations under the ACA.

Finally, the government set out an expansive interpretation of "avoids" under the False Claims Act. The hospitals argued that "avoid" meant to evade or escape by active and conscious action. The government took a much broader view, relying on *United States v. Lakeshore Medical Clinic*, 11-cv-00892 (E.D. Wisc. March 28, 2013), a case involving alleged physician upcoding. There, a clinic regularly audited and re-trained physicians. A relator complained that audits were not expanded upon discovering coding errors and that audits were not repeated every year.

The court agreed that the clinic's failure to further "investigate the possibility that it was overpaid…may have unlawfully avoided an obligation" to repay the government. This reasoning, relied upon by the government, suggests that any failure to investigate potential overpayments might constitute unlawful avoidance.

However, there is a potential safe harbor suggested by the government's brief. The government repeatedly cited legislative history stating that a reverse false claim will be complete "'once an overpayment is knowingly and improperly retained, without notice to the Government about the overpayment.'" That last phrase—"without notice to the Government about the overpayment"—is significant. It suggests that putting the government on notice of a potential overpayment may negate avoidance under the False Claims Act. If so, then early disclosure of potential overpayments may help limit reverse false claims liabilities.

Judge Ramos' Opinion

The government prevailed in *Kane*. Significantly, however, Judge Ramos declined to address the government's proposed "obligation" definition, under which any overpayment would trigger a duty to refund.

Instead, the court relied on the duty set out in the ACA. Judge Ramos held that an overpayment is "identified" under the ACA "where, as here, a person is put on notice that a certain claim may have been overpaid." The court thus concluded that the ACA's "sixty 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."

The court recognized that its broad construction of "identified" could "potentially impose a demanding standard of compliance in particular cases," and that a provider could "struggle[] to conduct an internal audit, and report[] its efforts to the Government within the sixty-day window." With a verbal shrug, however, Ramos lamented that "[t]he ACA itself contains no language to temper or qualify this unforgiving rule; it nowhere requires the Government to grant more leeway or more time to a provider who fails timely to return an overpayment but acts with reasonable diligence in an attempt to do so."

The court tempered this broad interpretation by its construction of the term "avoid." Judge Ramos noted that the failure to report and return payments within 60 days of being put on notice of claims cannot, without more, trigger False Claims Act liability. The statutes require knowing concealment or improper avoidance. "[W]ell-intentioned healthcare providers working with reasonable haste to address erroneous overpayments" would not run afoul of these additional elements, even if their inability to refund within 60 days triggered an ACA violation. The hospitals could seek to prove, at a later stage, "that they took steps to investigate or address the problem" and thus did not avoid their obligations.

The language and intent of the ACA, the court reasoned, leaves providers open to False Claims Act liability for slow-walking self-disclosures. In the court's view, providers must not only investigate potential overpayments, but they must also conclude those investigations promptly.

Yet the court rejected the hospitals' argument that any investigation, no matter how slow, would suffice to show that the hospitals were not avoiding repayment. The language and intent of the ACA, the court reasoned, leaves providers open to False Claims Act liability for slow-walking self-disclosures. In the court's view, providers must not only investigate potential overpayments, but they must also conclude those investigations promptly.

Subsequent Settlement

One day after Judge Ramos published his opinion in *Kane*, the Justice Department announced a reverse false claims-based settlement with Pediatric Services of America (PSA) consistent with the Kane opinion's logic. The government accused PSA of failing "to investigate credit balances on its books." The relator had alleged that PSA failed to investigate more than $3 million of credit balances, most of which appeared to be from Medicaid. In announcing the settlement, the Justice Department contended that PSA failed to comply with the 60-day requirements of the ACA by not investigating the credit balances and that PSA thereby violated the reverse false claims provision of the False Claims Act.

In language echoing Judge Ramos' opinion, the Justice Department warned that "[p]articipants in federal health care programs are required to actively investigate whether they have received overpayments and, if so, promptly return the overpayments." That warning comports with Ramos' conclusion that health-care providers on notice of potential overpayments must act diligently to investigate, report, and promptly return the overpayments, or face reverse false claims liability.

Implications

The Kane decision, the Justice Department's stated position in that case, and the recent PSA settlement lay the groundwork for more challenges for already heavily scrutinized health-care providers. Together, these precedents strongly suggest that entities on notice of potential government overpayments should diligently investigate, report, and return overpayments to avoid treble damages and penalties under the False Claims Act.

There will be much more litigation in this area, both challenging the Kane court's holding and seeking to flesh it out. In the meantime, health-care providers will struggle to determine when they could be considered "on notice" of an overpayment. Does every suspicion count? Which persons on notice put the organization itself on notice? Are providers on notice before they complete legal analyses of often-cumbersome reimbursement rules? How wide in scope must an investigation be? As long as the Kane decision stands, providers and their counsel will grapple with these questions.

Kane is far from the final word on these issues. Yet it provides some long-awaited guidance on the meaning of the reverse false claims provision and the ACA's report-and-return provision. Health-care providers should pay attention. Otherwise, they may incur significant False Claims Act liabilities and find themselves branded as fraudsters, even in cases, like *Kane*, where they received overpayments through no fault of their own and voluntarily returned every cent.

1. 31 U.S.C. §3729(a)(1)(G) (codified as amended in 2009); N.Y. State Fin. Law §189(1)(h) (codified as amended in 2013).
2. 31 U.S.C. §3729(b)(3); N.Y. State Fin. Law §188(4).
3. 31 U.S.C. §3729(b)(1)(A); N.Y. State Fin. Law §188(3)(a)(ii)-(iii).
4. 42 U.S.C. §1320a-7k(d)(1)-(2).
5. 42 U.S.C. §1320a-7k(d)(3).

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