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EXPERT ANALYSIS

Compliance Implications of the Rise of False Claims Act Cases Based on the 60-Day Rule

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As the government's primary tool for defending the public fisc against fraud, the False Claims Act, 31 U.S.C. § 3729, has become well-known for imposing huge penalties on health care providers who knowingly submit false or fraudulent claims for payment from government health programs.

With the importance of that mission, and with private whistleblowers having the ability to initiate these cases for the government — and thus reap a portion of the government's recoveries — the numbers of new FCA cases and total recoveries have hit record highs in recent years.

So it is no wonder that the Department of Justice and U.S. Department of Health and Human Services' Office of the Inspector General are showing rapidly increasing interest in a new theory: fraud liability based on the retention of overpayments from government health programs more than 60 days after the overpayments are "identified" by the health care provider.

Though the contours and limits of this nascent theory are still developing, recent DOJ enforcement actions make it clear that these cases will focus increasingly on the strength and rigorousness of providers' post-payment review and compliance programs.

THE 'REVERSE FALSE CLAIMS' PROVISION

Many health care providers are familiar with the FCA's provisions imposing liability for knowingly submitting, or causing to be submitted, false or fraudulent claims for payment of government funds. Less well-known, though, is the law's "reverse false claims" provision, which essentially imposes liability for deliberately failing to repay a debt owed to the government.

When first incorporated into the FCA with the 1986 amendments, this reverse-false-claims provision allowed for liability where the defendant knowingly made or used a false statement or record to "conceal, avoid, or decrease an obligation to repay" money to the government.[1]

Perhaps its application was limited to those who made false statements to avoid repaying a government debt, the so-called reverse FCA has been relatively seldom used as a primary basis for alleged liability. As a result, it has not been as developed in the case law.

The 2009 Fraud Enforcement and Recovery Act amendments to the FCA changed this provision by adding liability where one knowingly "conceals" or "improperly avoids or decreases an obligation to pay or transmit" funds to the government, even without the affirmative use of a false statement or record.[2]

Notably, the FERA amendments also gave new specificity to the "obligation" that can trigger reverse FCA liability, defining it as "an established duty" arising from various possible sources. These sources include contractual and statutory requirements and, perhaps most notably, "the retention of any overpayment."

The accompanying Senate report explained that Congress did not intend for the reverse FCA to apply to an unintentional overpayment retention during a "statutory or regulatory process for reconciliation." But it also said that the "knowing and improper retention of an overpayment beyond or following the final submission of payment as required by statute or regulation" would be actionable.[3]

HHS GUIDANCE ON THE 60-DAY RULE

One of the potential "obligations" that may serve as a basis for reverse FCA liability is the retention of overpayments of government health program funds. Not long after passage of the FERA amendments, Congress again addressed the overpayments issue in the Medicare and Medicaid program integrity provisions of the 2010 Patient Protection and Affordable Care Act.

The Affordable Care Act imposed a requirement that anyone receiving an "overpayment" — defined as received Medicare and Medicaid funds to which the person was not entitled — must report and return it within 60 days after the date on which it was "identified" or any corresponding cost report was due, whichever comes first.[4]

The Affordable Care Act explicitly provided that any overpayment retained beyond this report-and-return period is an "obligation" for purposes of reverse FCA liability.[5]

Thus, health care providers face expansive FCA liability — which includes mandatory treble damages and civil penalties — for knowingly retaining overpayments beyond the 60-day period set by the Affordable Care Act.

CMS' failure to conclusively decide on the meaning of its own overpayment rules has not deterred the Justice Department from pursuing related "reverse FCA" cases.

Clearly, the most crucial question for providers seeking to comply with that rule, then, is when has one "identified" an overpayment and thereby started the 60-day clock? One might think that "identified" describes only an affirmative awareness of something, but in its initial rulemakings for the Medicare program, the Centers for Medicare and Medicaid Services construed the term to mean either "actual knowledge of the existence of the overpayment or act[ing] in reckless disregard of the overpayment."[6]

And in May 2014, CMS issued a final rule with a potentially even more expansive interpretation, adding that a Medicare Advantage Organization or Part D plan sponsor has "identified" an overpayment — and started the 60-day clock — when it "has determined, or *should have determined through the exercise of reasonable diligence*, that [it] has received an overpayment."[7]

CMS did not specify what constitutes "reasonable diligence," but noted that, "at a minimum," it would include "proactive compliance activities conducted in good faith by qualified individuals to monitor for the receipt of overpayments."[8]

Although CMS' guidance for Medicare Parts C and D was due to go in effect in February, the agency announced that finalizing the rule will take another year. It said that it needed to address "significant policy and operational issues" in fashioning the final rule and needed to coordinate with DOJ and HHS-OIG.[9]

CMS' failure to conclusively decide on the meaning of its own overpayment rules has not deterred DOJ from pursuing related "reverse FCA" cases, however. Two key developments in DOJ enforcement this summer showed that providers should not wait until the dust settles on CMS' rulemakings to take a hard look at their payment-related compliance programs.

A NEW FRONTIER

On Aug. 4, DOJ announced a "first of its kind" settlement of allegations that Pediatric Services of America violated the FCA by failing to return overpayments from federal health programs.[10] In its description of the settled conduct, DOJ alleged Pediatric Services violated the FCA by maintaining or writing off "credit balances on its books" without investigating whether those credit balances were the result of government overpayments.[11]

The two *qui tam* complaints originating the investigation included other allegations and theories.[12] But DOJ's announcement of the $6.88 million settlement focused squarely on the

failure to investigate overpayments based on the company's books, with HHS-OIG calling the case "precedent-setting."[13] As part of the settlement, Pediatric Services also entered into a corporate integrity agreement related to the allegations.

In the same week as the Pediatric Services settlement came the first judicial opinion construing the 60-day rule, demonstrating that courts are also not going to wait for CMS' guidance to allow enforcement of the rule. *United States ex rel. Kane v. Healthfirst et al.*[14] arose out of the government's first-ever intervention in allegations of FCA liability based on 60-day rule violations.

In *Kane*, the United States and state of New York filed a complaint alleging that defendant Continuum Health Partners, an operator of co-defendant nonprofit hospitals in New York, violated the "reverse FCA" by failing to timely investigate potential overpayments from secondary payers, including Medicaid.

Specifically, the government alleged that in 2009, a glitch in the software of a private insurance program for Medicaid-eligible enrollees, Healthfirst Inc., caused Healthfirst to send remittances to enrolled providers erroneously informing them they could seek additional payment for their services from secondary payers such as Medicaid. This, in turn, resulted in providers in the Continuum system claiming and receiving Medicaid payments to which they were not entitled.

The subsequent timeline of the allegations in *Kane* appears to have been a key part of how the court viewed the government's claims — and is a potential warning for other providers' own compliance with the overpayment rules.

In September 2010 state auditors allegedly informed Continuum of the erroneous payments caused by the glitch, which was fixed in December 2010. Several Continuum employees, including the then-employee relator Robert Kane, began examining Continuum's billing data to "identify" potential affected claims. In February 2011, Kane allegedly sent to Continuum management a spreadsheet listing affected erroneous claims while noting that further analysis was needed.

The government acknowledges that Kane's list of claims was overbroad, but it alleges that Continuum "did nothing further" with the analysis and reimbursed the state for just five claims.

According to the complaint, after the state again brought incorrect claims to the company's attention, Continuum began making repayments in April 2011 — but did not complete the repayments for nearly two more years. The government alleges that Continuum therefore "fraudulently delay[ed] its repayments" for up to two years after Continuum knew of the extent of the overpayments.

In other words, the violations alleged by the government are not just of failing to make repayments, but of failing to make the repayments quickly enough — first by failing to take timely steps to identify the specific overpayments, and then by failing to quickly repay them.

The *Kane* defendants filed a motion to dismiss the government's complaint, arguing primarily that the allegations did not amount to a "reverse FCA" violation because they did not plead an "obligation" under the statute. More specifically, the defendants argued that Kane's list of claims had not "identified" overpayments — and thus started the 60-day repayment clock — because it had not "classified [them] with certainty."

In response, the government argued for a looser definition of "identified" that bore a striking similarity to CMS' recent revised draft guidance: where the provider "has determined, or *should have determined through the exercise of reasonable diligence*," the receipt of an overpayment.

The court adopted the government's proffered "reasonable diligence" standard and denied the defendants' motion to dismiss. Rather than rely on CMS' draft guidance in the Medicare context — which it viewed as "useful" but "entitled to no formal deference"— the court viewed this issue as "a novel question of statutory interpretation."

After finding the term "identified" has no "plain meaning" as it is used in the Affordable Care Act, the court notably found that it was more congruous with the legislative intent behind the False Claims Act to start the 60-day clock "when a provider is put on notice of a potential overpayment."

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The court noted that the FCA does not require the amount of an obligation to be "fixed" for a duty to repay to accrue under the statute.

Finally, the court found that adopting the "conclusively established" standard would create a "perverse incentive" for the provider to "delay learning the amount due and relegating the 60-day period to merely the time within which they would have to cut the check."

In the *Kane* court's view, these considerations outweighed what it recognized could be a difficult compliance burden on providers. The court observed that, under the "reasonable diligence" standard, a provider could still accrue an actionable "obligation" if it receives notice of an overpayment, and "struggles to conduct an internal audit and reports its efforts to the government within the 60-day window," but fails to complete the repayment in that time.

But in a situation where a provider is "working with reasonable haste to address erroneous overpayments," the court stated that the provider "would not have acted with the reckless disregard, deliberate ignorance, or actual knowledge of an overpayment required to support an FCA claim."

While this is surely a helpful statement about the limits of FCA applicability in these cases, it is perhaps cold comfort to the hypothetical provider that could still technically be subject to administrative penalties for the overpayment after day 60.

But the import of the opinion in *Kane* remains: Providers must demonstrate good faith and use "reasonable haste" in addressing potential overpayments.

The legislative intent behind the False Claims Act starts the 60-day clock ticking "when a provider is put on notice of a potential overpayment," the Kane *court said.*

IMPLICATIONS

If DOJ's recent enforcement activity is any indication, the court's opinion in *Kane* is just the first entry in what is sure to be a continued line of cases involving application of FCA fraud liability to alleged 60-day rule violations. To be sure, there are difficult questions still to be answered about the nexus of the 60-day rule and the "reverse False Claims Act."

For example, how does the rule apply where a provider needs more than 60 days to determine not just the *amount* of a repayment, but whether the law requires repayment at all? The Supreme Court has counseled that, in a situation like that, a defendant's good-faith interpretation of a legal requirement can negate scienter under laws like the FCA.[15]

With DOJ taking an increasingly aggressive look at the "reverse FCA" theory under the HHS repayment rules, this question and others about the meaning of "reasonable diligence" are sure to be the subject of enforcement actions — and perhaps further agency guidance.

But already it is clear that the sufficiency of providers' compliance programs — and particularly any post-payment review efforts — will garner more focus than ever before. The upshot of the evolution of the 60-day repayment rule to a "reasonable diligence" standard and its application in DOJ enforcement actions is not only that providers must seriously investigate evidence or reports that they received government funds in error, but that they must do so expeditiously — perhaps even before determining the full amount owed.

To act with the expediency suggested in *Kane* will likely require providers to have post-payment review plans already in place and to implement them rigorously and efficiently. As *Kane* suggests, having robust plans in place can help a provider avoid fraud liability even if the complexity of the potential overpayment or its investigation make compliance with the 60-day rule impossible.

NOTES

1 31 U.S.C. § 3729(a)(7) (1986).

2 31 U.S.C. § 3729(a)(1)(G) (2009).

3 S. Rep. 111-10 (2009) at 15.

4 42 U.S.C. § 1320a-7k(d).

5 *Id.*

[6] Medicare Program; Reporting and Returning of Overpayments, 77 Fed. Reg. 9,179, at 9,179-9,187 (proposed Feb. 16, 2012) (proposed rule for Medicare Parts A and B); Medicare Program; Contract Year 2015 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs, 79 Fed. Reg. 1918 (proposed Jan. 10, 2014) (proposed rule for Medicare Advantage and Medicare Part D).

[7] *Id.* at 79 Fed. Reg. 29,844, at 29,958, 29,963 (May 23, 2014) (to be codified at 42 C.F.R. pts. 422 and 423) (emphasis added).

[8] *Id.* at 29,923.

[9] Medicare Program; Reporting and Returning of Overpayments; Extension of Timeline for Publication of the Final Rule, 80 Fed. Reg. 8247 (Feb. 17, 2015).

[10] *See* Press Release, Office of Pub. Affairs, U.S. Dep't of Justice, Pediatric Services of America and Related Entities to Pay $6.88 million to Resolve False Claims Act Allegations (Aug. 4, 2015), http://www.justice.gov/usao-sdga/pr/pediatric-services-america-and-related-entities-pay-688-million-resolve-false-claims.

[11] *Id*.

[12] *See United States ex rel. Odumosu v. Pediatric Servs. of Am. Healthcare,* No. 1:11-CV-1007-AT, complaint filed (N.D. Ga. Mar. 30, 2011); *United States ex rel. McCray et al. v. Pediatric Servs. of Am. et al.,* No. CV4:13-127, *amended complaint filed* (S.D. Ga. Dec. 11, 2013).

[13] *See* Press Release, *supra* note 10.

[14] *United States ex rel. Kane v. Healthfirst Inc.,* No. 11 Civ. 2325, 2015 WL 4619686 (S.D.N.Y. Aug. 3, 2015).

[15] *See Safeco Ins. Co. of Am. v. Burr,* 551 U.S. 47, 68 (2007) (holding that defendant was not in "reckless disregard" under Fair Credit Reporting Act if it adopted a reasonable, though incorrect, interpretation of unclear statutory provision).

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