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The ACA 60-Day Overpayment Rule and Related Compliance Challenges

Unpacking the Affordable Care Act's 60-day Overpayment Rule after the First Settlement and Decision Addressing Noncompliance

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On August 3, 2015, the U.S. District Court for the Southern District of New York issued the first judicial opinion[1] applying the Affordable Care Act (ACA) "60-day overpayment rule."[2] This rule, also known as the "report and return" rule, requires health care providers to report and return overpayments made by Medicare or Medicaid within 60 days of when the provider identifies the overpayment.[3] One day later, on August 4, 2015, the U.S. Attorney's Office for the Southern District of Georgia announced a "first of its kind" settlement by several pediatric service providers who agreed to pay almost seven million dollars to resolve allegations that they failed to comply with the report and return rule.[4] This article explores these recent developments and their compliance-related implications for health care providers and their counsel.

U.S. ex rel. Kane v. HealthFirst

This case involves two New York hospitals, Beth Israel and St. Luke's-Roosevelt Hospital Center, that were previously part of a network of non-profit hospitals operated and coordinated by Continuum Health Partners, Inc. (Continuum). Pursuant to Medicaid regulations, the hospitals were entitled to receive, as payment for services rendered to Medicaid managed care patients, only the amount paid by the managed care organization (MCO) and were not permitted to seek additional payments from Medicaid or the patients. The relator, Robert Kane, a former Continuum billing employee, alleged that beginning in or around early 2009 and continuing through approximately late 2010, Continuum submitted improper claims to N.Y. Medicaid on behalf of the

hospitals. Kane alleged that Continuum submitted claims for additional payments associated with Medicaid managed care claims that had already been paid at the contractually fixed payment rate by HealthFirst, a private Medicaid MCO, as a result of erroneous coding in electronic remittances issued by HealthFirst.

In September 2010, the New York Office of the State Comptroller identified a small number of Medicaid claims submitted by Continuum on behalf of the hospitals that incorrectly billed Medicaid as a secondary payor. Kane alleged that Continuum became aware of, or "identified," the much larger extent of potential overpayments associated with the billing error on February 4, 2011, via an email that Kane sent Continuum executives. The email included a summary of Kane's internal review and a spreadsheet of approximately 900 claims, totaling over $1 million, that may have been wrongly submitted to, and subsequently paid by, Medicaid as a secondary payor.

According to Kane, after receiving his email, Continuum failed to take steps to repay all of the affected claims within 60 days of when these claims were identified, thereby violating the 60-day overpayment rule. Instead, Kane said that Continuum proceeded to repay only small batches of affected claims, some of which were brought to Continuum's attention by the Comptroller, over the following two-plus years. Continuum did not make final repayments until March 2013, and more than 300 of the claims were repaid only after the federal government issued a civil investigative demand (CID) to Continuum concerning these claims in June 2012. Despite eventually returning the overpayments, Continuum may face liability for not doing so in a timely manner. The Department of Justice (DOJ) and the New York State Attorney General chose to intervene in the case on June 27, 2014, citing Continuum's failure to report and return the excess payments within the 60-day window established under the ACA.

The eventual outcome of this case will turn, at least in part, on when Continuum is deemed to have "identified" the overpayments at issue, which the Court noted is a novel question of statutory interpretation. The relator and government allege that the relator's email to Continuum in February 2011 constitutes Continuum "identifying" the overpayments within the meaning of the federal civil False Claims Act (FCA).[5] Therefore, they argue, Continuum violated the report and return rule by failing to return the overpayments within 60 days. The defendants, on the other hand, argue that the relator's February 2011 email simply identified potential overpayments and not actual overpayments. Actual overpayments were not "identified" until much later, they argue, when the claims at issue were examined by qualified billing specialists. For support, defendants point to Congress' decision to adopt the Senate version of the ACA, which contained a similar "report and return" provision but stated that "known," rather than "identified," overpayments had to be reported and returned within 60 days.

The Court did not adopt a clear definition of the term "identify" in ruling on the defendants' motion to dismiss. However, in denying the motion, the Court did appear to reject the argument that a provider must have actual knowledge of an overpayment before the provider can be deemed to have "identified" it. How much less is required, however — *e,g,*, reckless disregard, deliberate indifference, gross negligence, negligence — remains to be seen.

PSA Settlement

On August 4, 2015, the DOJ announced the first settlement in a case involving an alleged violation of the ACA's 60-day overpayment rule. In the joint settlement of *United States ex rel. Odumosu v. Pediatric Services of America, Inc.*[6] and *United States ex rel. McCray v. Pediatric Services of America, Inc. et al.*,[7] the providers at issue agreed to pay $6.88 million to settle allegations

surrounding overpayments due under the ACA's 60-day overpayment rule. The whistleblowers alleged that the providers had, among other things, knowingly failed to disclose and return overpayments received from Medicare and Medicaid. As in *Kane*, these overpayments apparently involved billing errors stemming from a computer glitch.

Discussing the settlement, U.S. Attorney for the Northern District of Georgia John Horn said, "[p]articipants in federal health care programs are required to actively investigate whether they have received overpayments and, if so, promptly return the overpayments…This settlement is the first of its kind and reflects the serious obligations of health care providers to be responsible stewards of public health funds."[8]

Implications

There are a number of important takeaways for health care providers and their counsel after these nearly concurrent developments in early August.

- First, the *Kane* court at least suggested that an overpayment has been identified — and the 60-day overpayment clock begins to tick — where a health care provider is "put on notice" of a potential overpayment. If ultimately adopted, that standard would establish a far higher bar than that proposed by the defendants in *Kane*, which is that the 60-day window opens only once a potential overpayment has been "conclusively ascertained." Providers will need to closely monitor the jurisprudence on this issue as it develops because the direction in which the courts ultimately head will have significant and obvious ramifications for provider billing, compliance, and legal departments.
- Second, providers should be aware that the *Kane* case and overpayment settlement will only encourage government enforcers and whistleblowers alike to pursue cases under this theory. Accordingly, note that overpayment cases may increase exponentially.
- Third, providers and their counsel should be wary of the "prosecutorial discretion" standard introduced by the *Kane* court. In *Kane*, the court noted the defendants' argument that verifying the accuracy of hundreds of overpayments is a cumbersome task, and one that cannot always be completed within 60 days. The court suggested the government could address such situations through the exercise of "prosecutorial discretion." This is hardly comforting, however, since private whistleblowers and their counsel are hardly known for exercising such discretion.

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Endnotes:

1. *U.S. ex rel. Kane v. HealthFirst, Inc. et al.*, No. 11-CV-2325 (S.D.N.Y. Aug. 3, 2015).
2. The ACA established a new section to the Social Security Act, § 1128(j), codified at 42 U.S.C. § 1320-7k(d).
3. 42 U.S.C. § 1320-7k(d).
4. U.S. Dept. of Justice, Press Release, *Pediatric Services of America And Related Entities to Pay $6.88 Million to Resolve False Claims Act Allegations* (Aug. 4, 2015), *available at* www.justice.gov/usao-sdga/pr/pediatric-services-america-and-related-entities-pay-688-million-resolve-false-claims.
5. 31 U.S.C. § 3729 *et seq*.
6. United States ex rel. Odumosu v. Pediatric Services of America, Inc,, No. 11-cv-1007 (N.D. Ga., Aug. 3, 2015).
7. United States ex rel. McCray v. Pediatric Services of America, No. 4:13-cv-127 (S.D. Ga., Aug. 3, 2015).
8. U.S. Dept. of Justice, Press Release, *Pediatric Services of America And Related Entities to Pay $6.88 Million to Resolve False Claims Act Allegations* (Aug. 4, 2015), available at www.justice.gov/usao-sdga/pr/pediatric-services-america-and-related-entities-pay-688-million-resolve-false-claims.

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