Health Law Alert: Case Against New York Health System May Shape the 60-Day Overpayment Rule

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HEALTH LAW ALERT: CASE AGAINST NEW YORK HEALTH SYSTEM MAY SHAPE THE 60-DAY OVERPAYMENT RULE

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New York's Mount Sinai Health System is involved in a high-stakes False Claims Act (FCA) suit alleging failure to comply with the Affordable Care Act's (ACA) 60-day overpayment rule. This is the first time the Department of Justice (DOJ) has acted to enforce the rule, which is particularly significant being that the Centers for Medicare & Medicaid Services (CMS) has yet to issue a final rule for the provision. Although CMS indicated in its proposed rule from 2012 that the statutory obligation to report and return overpayments was in effect despite the lack of a regulation that filled in some of the details left out of the statutory mandate, industry observers were not sure whether DOJ would actually use the FCA to enforce the 60-day rule without this regulatory guidance. The Mount Sinai case answers that question. Further, due to the lack of formal guidance, this case will give insight into the DOJ's enforcement position and how the 60-day rule will be interpreted by federal courts.

The 60-Day Rule

The ACA made a number of changes to the Medicare program to enhance the federal government's ability to combat fraud and recover overpayments. The 60-day rule was a key part of this effort. Section 6402 of the ACA, codified in the Social Security Act at 42 U.S.C. 1320a-7k, requires providers of services or supplies under Medicaid or Medicare to report and return "overpayments." "Overpayment" is defined as, "any funds that a person receives or retains . . . to which the person, after applicable reconciliation, is not entitled. . . ." The term "person" includes providers of services, suppliers, Medicaid managed care organizations, Medicaid Advantage organizations, or PDP sponsors.

Overpayments must be reported and returned by the latter of: (1) the date which is 60 days after the date on which the overpayment was identified; or (2) the date any corresponding cost report is due, if applicable. The

term "identify" is a crucial component of liability as it signals the date on which the 60-day clock begins to run. However, the 60-day rule does not define the term. On Feb. 16, 2012, CMS issued a proposed rule that clarified an overpayment is "identified" if "the person has actual knowledge of the existence of the overpayment or acts in reckless disregard or deliberate ignorance of the overpayment." However, over two years have passed and a final rule has yet to be released. Click here to read GPM's initial Health Law Alert on the 60-day rule when it was first proposed.

The ACA also created FCA liability for individuals who retain overpayments longer than 60-days. Overpayments retained after the 60-day window are considered "obligations" under the FCA, entitling the government or qui tam relators to pursue civil penalties. CMS reportedly received a significant volume of comments pushing back against the proposed rule. Among the issues with the initial proposal were: (1) a look-back period many providers felt to be extremely long (10 years); (2) lack of clarity about when the 60-day clock starts running; (3) uncertainty about whether providers could continue to address claims issues through adjustment bills or other means, as opposed to the report and return standard found in the proposed rule; and (4) uncertainty about what to do if the amount of "overpayment" cannot be quantified. Underlying these concerns was a general perception that the proposed rule sought to make the FCA the vehicle for tackling even the most minute or unintentional billing errors.

The Case Against Continuum Health Partners, Inc.

The case against Mount Sinai steams from erroneous billing of Medicaid beginning in 2009. Continuum Health Partners, Inc. (also known as Continuum, now part of the Mount Sinai health system) provided services to Medicaid-managed care patients enrolled with Healthfirst. While Medicaid regulations required Continuum to accept Healthfirst's reimbursement as payment in full, an alleged computer coding error indicated New York Medicaid as a secondary payment source. Consequently, Continuum balance-billed Medicaid and Medicaid paid many of the claims.

In Sept. 2010, the New York Office of the State Comptroller discovered a small number of improper claims. Continuum performed an internal investigation, led by former employee Robert Kane. According to the complaint, Kane subsequently concluded 900 specific claims totaling over $1 million may have been erroneously submitted to and paid by Medicaid as a secondary payor. For reasons unknown, Kane was terminated by Continuum.

On April 5, 2011, Kane filed a complaint against Continuum as a *qui tam* relator. Three years later, the United States filed a notice of partial intervention. Continuum filed a motion to dismiss on Sept. 22, 2014, arguing Kane did not specifically identify overpayments during his investigation, but rather provided a list of claims that were potentially affected by the coding error. Continuum attached an exhibit to the motion that indicates approximately half of the claims on Kane's list were not billed or paid by Medicaid. Accordingly,

Continuum argued "notice" of potential overpayments is distinct from "identification," and only the later can give rise to the 60-day report and return obligation.

Important Issues to Keep an Eye On

As noted above, CMS made clear in the 2012 proposed regulation that the ACA mandate on reporting and returning overpayments within 60-days of identification—and the potential FCA exposure for failing to do so—were in effect under the ACA. Some industry observers took issue with this view, due mainly to the lack of statutory clarity on several key issues and the absence of a final regulation filling in some of the details. DOJ's enforcement position demonstrates that the 60-day mandate is in fact effective, and that providers will need to resolve any issues they see with the statutory requirements if they determine that an "overpayment" exists. Lack of guidance from CMS will not be much of an excuse if providers and suppliers are not able to meet their obligations within the requisite period of time.

The Continuum case may help define the parameters of the 60-day rule. The case will largely turn on whether the court finds Continuum in fact "identified" the overpayments and then failed to return them within 60-days. Because the proposed regulatory definition has not been finalized, the court will determine when the overpayments were "identified." In the absence of a final regulation, the court's interpretation may provide a baseline for future 60-day enforcement cases and will give providers, regulators and other *qui tam* relators insight on when the clock will start to run.

Another thing to watch for is what the court has to say about how to calculate damages if Continuum is found guilty. Violators of the 60-day rule face severe consequences: treble damages, plus fines of up to $11,000 for every improperly retained overpayment, plus civil monetary penalties of up to $10,000 *per day* for each day that the overpayment was retained beyond the 60-day window. In this case, the DOJ is seeking the maximum FCA penalty. Moreover, the court could exclude Continuum from the Medicare program. While DOJ's positions may reflect negotiating strategies, the outcome in this case may provide insight into how some courts will be figuring out how to assess damages.

If you have comments or questions regarding the 60-day overpayment rule, please contact Jesse Berg at jesse.berg@lathropgpm.com (612.632.3374) or Tim Johnson at timothy.johnson@lathropgpm.com (612.632.3208).