New York Court Rules Against Hospital Defendants in ACA "60-Day Rule" Case

by Lori C. Ferguson

Under the Affordable Care Act ("ACA"), providers who bill federal health care programs, including Medicare and Medi-Cal, must report and repay overpayments within 60 days of identifying them. If a provider fails to meet this deadline, the overpayments may be treated as false claims under the False Claims Act ("FCA"), subjecting the provider to significant penalties and potential exclusion from participation in federal health care programs.

However, the ACA does not define what it means to "identify" an overpayment, and the Centers for Medicare and Medicaid Services ("CMS") have not issued final guidance clarifying the issue. Larger providers such as hospitals or health systems process and submit thousands of claims per month. When does a suspected billing anomaly rise to the level of being an "identified" overpayment that starts the 60-day repayment clock?

A federal court in New York recently examined this question in an FCA "whistleblower" action, and its conclusion is not favorable to health care providers. In *Kane v. HealthFirst, Inc.*,[1] the whistleblower prepared an audit spreadsheet for his employer, the operator of a network of non-profit New York hospitals, detailing 900 possible state Medicaid overpayments, in February 2011. The employee was fired four days after presenting the report to his employer. He later filed the FCA whistleblower action against the providers, alleging that for over two years they avoided following up on claims he identified as overpayments.

The defendants moved to dismiss the case, noting that it took two years to specifically determine which of the 900 claims were overpayments, and that before this determination, the claims were only "*potential*" overpayments, rather than *"identified"* overpayments, because they were not yet "classified with certainty." The *Kane* court rejected the defendants' explanation and concluded that as long as a provider is put *on notice* of a potential overpayment, the 60-day repayment clock is triggered.

What does the *Kane* opinion mean for California providers? Although the opinion is not binding law in California and merely represents the denial of a pretrial motion to dismiss, *Kane*'s lengthy and well-organized analysis may influence CMS rulemaking on this issue, which has been stalled for several

years.

In 2012, CMS issued proposed rules stating that for the purpose of the 60-day repayment rule, an overpayment is identified when a provider has actual knowledge of the overpayment or otherwise recklessly or deliberately disregards the possibility that an overpayment exists.[2] The *Kane* opinion discusses the intent and legislative history of the 2012 proposed rules, compares the rules to analogous federal laws, and provides regulators with an example of how a lower court would interpret CMS's proposed rules. By doing so, the *Kane* opinion may provide CMS regulators with the validation they have been waiting for to issue finale rules, which will have a sweeping effect on providers nationwide.

[1] *Kane v. HealthFirst, Inc., et al.*, 2015 U.S. Dist. LEXIS 101778, (S.D.N.Y, Aug. 3, 2015).

[2] 77 Fed. Reg. 9179, 9187 (Feb. 16, 2012).

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