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FCA Enforcement Action to Watch: Government Intervened in Reverse False Claims Case

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With a motion to dismiss pending in the United States District Court for the Southern District of New York, ***United States of America ex rel. Kane v. Continuum Health Partners, Inc.***, Case No. 11-2325, is the ***False Claims Act (FCA)*** case to watch in 2015. It is the first "***reverse false claim***s" case where the United States intervened, and its only allegation involves a failure to timely report and refund overpayments to the government.

In 2010, the *Affordable Care Act (ACA)* modified the FCA's reverse false claims provision (31 U.S.C. § 3729(a)(1)(G)), making a party liable for failing to report and return an overpayment within 60 days of the date it is "identified." *See* 42 U.S.C. § 1320a?7k(d). Five years after the passage of the ACA, however, it remains unclear what it means for an overpayment to be "identified," thereby triggering the 60-day clock. The Centers for Medicare and Medicaid Services (CMS) has not issued any guidance concerning refunding overpayments to Medicaid. In February 2012, CMS issued proposed regulations on this topic for Medicare Parts A and B, which it has yet to finalize. In fact, CMS just announced, on February 13, 2015, that it will delay its final guidance until at least February 2016—likely well after the district court issues its decision in *Continuum Health*.

According to the government's complaint, filed on June 27, 2014, three hospitals in New York City operated by Continuum Health (which is now part of Mount Sinai Health System) submitted improper claims to Medicaid in 2009 and 2010, as a result of a glitch with its billing software. The New York State Comptroller first notified Continuum Health in September 2010 that it had erroneously billed Medicaid for a small number of claims. Continuum Health then conducted an internal investigation. On February 4, 2011, the relator e-mailed a spreadsheet to his superiors at Continuum Health with what he believed to be about 900 improperly-submitted claims resulting from the same software issue. Four days later, Continuum Health terminated the relator.

Over the next two years, Continuum Health refunded the overpayments associated with the initial list of 900 claims. The government alleges that Continuum Health made these refunds largely in response to continued inquiries from the NYS Comptroller about additional claims. And, it claims that Continuum Health refunded 300 of the overpayments only after it received a Civil Investigative

Demand from the U.S. Department of Justice. Nonetheless, the government did not intervene in the case until a year *after* Continuum Health refunded all overpayments to Medicaid.

In its motion to dismiss, Continuum Health makes three arguments:

> *First*, it contends that it had no "obligation" to report and refund the overpayments. The relator's February 4, 2011, e-mail did not "identify" any overpayments, thereby triggering the 60-day clock. Rather, the e-mail was a preliminary list of potential overpayments that, by the relator's own admission, required "further analysis to corroborate his findings." According to Continuum Health, the government's position that "mere notice of a potential but unconfirmed overpayment" will "identify" that overpayment is untenable. Indeed, 60 days is not enough time to complete the sort of complex factual investigation and legal analysis that is typically required to determine whether there is an actual overpayment.
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> *Second*, Continuum Health argues that, even if an "obligation" existed after the relator sent his e-mail, it did not knowingly "conceal[]" or "avoid[]" that obligation. Continuum Health argues that concealing and avoiding require affirmative action, *not* the failure to act.
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> *Finally*, Continuum Health claims that it does not have an obligation to repay the *federal* government, because Medicaid is operated at the state level. Consequently, any alleged failure to report and refund overpayments does not create liability under the FCA.

The government responds to Continuum Health's arguments in turn.

> *First*, it argues that when construing the term "identified," the court should look to CMS guidance concerning refunding overpayments to Medicare Advantage and Part D. Under that guidance, a healthcare provider "has identified an overpayment" when it "has determined, *or should have* determined through the exercise of reasonable diligence, that [it] has received an overpayment." According to the government, Continuum Health failed to act with reasonable diligence after it received the relator's e-mail. The government rejects Continuum Health's interpretation of "identified"—claiming that it allows the provider to choose when, or even if, to start the 60-day clock, despite how much information it possesses concerning the overpayment.
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> *Second*, the government argues that Continuum Health "knowingly avoid[ed]" its repayment obligation because, after it learned that it received overpayments, it "failed to take remotely reasonable steps to return those funds to Medicaid."
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> *Finally*, the government contends that the FCA has always reached Medicaid claims. Indeed, according to the government, the ACA defines "overpayment" to specifically include overpayments to Medicaid.

Although briefing closed with Continuum Health's reply on December 8, 2014, for healthcare providers throughout the United States, many issues remain open. With further CMS guidance on the

meaning of “identified” delayed for another year, the decision in *Continuum Health* will likely provide the first guidance about what the law requires. We will continue to monitor this case and keep you updated.

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