IDENTIFYING SCHRÖDINGER'S CAT: *EX REL. KANE* AND THE FUTURE OF THE SIXTY DAY REPORT AND RETURN RULE

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On August 3, 2015, the Southern District of New York ("S.D.N.Y.") issued its long-awaited Opinion and Order denying the defendants' motion to dismiss the case *Ex Rel. Kane v. Healthfirst, Inc., et al.*[1] Healthcare providers have waited with baited breath for a court's first impression of the Sixty Day Report and Return Rule (the "Rule"). The Rule is part of the Affordable Care Act's ("ACA") Medicare and Medicaid Program Integrity Provisions which requires providers to report and return overpayments within sixty days of identification.[2] Issues with the law's statutory construction have frustrated its interpretation and implementation. Glaringly, the law does not define when an overpayment is "identified" yet provides definitions for the words "knowing" and "knowingly" without using them

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[1] Kane *ex rel.* U.S. v. Healthfirst, Inc., 120 F. Supp. 3d 370 (S.D.N.Y. 2015).

[2] 42 U.S.C. § 1320a-7k(d) (2016).

http://dx.doi.org/10.18060/3911.0022

elsewhere in the statute.[3] The implementation of the Rule hinges on the definition of "identified," and the S.D.N.Y. took the statute beyond what its language may bear in order to provide what it feels is the proper reading.

I. BACKGROUND

Kane ex rel U.S. v. Healthfirst Inc. ultimately stems from a software problem.[4] Healthfirst, "a private non-profit health insurance program," administers a Medicaid managed care program whose beneficiaries receive services at three New York hospitals operated by Continuum Health Partners.[5] This managed care program operates on what is called a capitation model, where the New York State Department of Health ("DOH") provides a monthly payment for the beneficiaries as opposed to the fee-for-service model.[6] Normally, when Healthfirst sends payments to hospitals on behalf of these beneficiaries, a code is included which tells providers they may not seek out secondary payment for the services beyond co-payments from certain patients.[7] Continuum's billing software erroneously translated the code as one permitting secondary payors.[8] The hospitals automatically generated bills to entities such as the DOH, which mistakenly paid some of these improper claims.[9]

In September 2010, the New York State Comptroller's office questioned Continuum about the incorrect billing.[10] After discovering the problem's cause, Continuum tasked Relator Kane with determining "which claims had been improperly billed."[11] In early February 2011, Kane emailed a spreadsheet containing more than 900 claims with the erroneous code to several members of Continuum's

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[3] *Id.* CMS recently issued a Final Rule defining "identified," discussed *infra* section V.

[4] *Kane,* 120 F. Supp. 3d 370 at 375.

[5] *Id.* at 376.

[6] *Id.*

[7] *Id.*

[8] *Id.*

[9] *Id.*

[10] *Id.*

[11] *Id.* at 377.

management.[12] He indicated that further analysis was needed and that the spreadsheet gave "some insight to the magnitude of the issue."[13]

Continuum terminated Kane's employment four days later and allegedly "did nothing further" with Kane's analysis.[14] It reimbursed the DOH "for only five improperly [paid] claims."[15] The Comptroller identified several further "tranches of wrongful claims, which it brought to Continuum's attention" through most of 2011 and early 2012.[16] The government issued a Civil Investigative Demand in June 2012 seeking more information on the overpayments, and Continuum never shared Kane's email with the Comptroller.[17] Continuum did not fully reimburse the DOH until March 2013, a little over two years from Kane's email.[18] Ultimately, roughly half of Kane's listed claims resulted in overpayments.[19]

The government alleges that Kane's email "identified" overpayments under the Rule, thus triggering the countdown back in February 2011.[20] The defendants filed a motion to dismiss the case on the grounds that the email did not identify overpayments, amongst other reasons.[21] The court denied the motion and provided insight for its agreement that the clock began with the email.[22] This article will focus on the issue of "identified" and not other portions of the order such as pleading requirements under Rule 9(b).

The Rule provides in relevant part:

> **(2) Deadline for reporting and returning overpayments**
> An overpayment must be reported and returned under paragraph (1) by the later of—

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[12] *Id.*
[13] *Id.*
[14] *Id.*
[15] *Id.*
[16] *Id.* at 377-78.
[17] *Id.* at 378.
[18] *Id.*
[19] *Id.*
[20] *Id.*
[21] *Id.*
[22] *Id.*

> (A) the date which is 60 days after the date on which the overpayment was identified…
> (3) Enforcement
> Any overpayment retained by a person after the deadline for reporting and returning the overpayment under paragraph (2) is an obligation (as defined in section 3729 (b)(3) of title 31) for purposes of section 3729 of such title.
> (4) Definitions
> In this subsection:
> (A) Knowing and knowingly
> The terms "knowing" and "knowingly" have the meaning given those terms in section 3729 (b) of title 31.
> (B) Overpayment
> The term "overpayment" means any funds that a person receives or retains under subchapter XVIII or XIX to which the person, after applicable reconciliation, is not entitled under such subchapter.[23]

II. THE RULE'S INTERPLAY WITH THE FALSE CLAIMS ACT

A threshold question to ask when reviewing this law is what exactly does it add to the statutory lexicon? The False Claims Act ("FCA") already prohibits holding on to money owed to the government.[24] What this law provides is a "clock." It tells providers how long they have to report and return an overpayment before potential "reverse FCA" liability attaches, where an entity is liable for failing to return money to which it is not entitled. But when does the clock start? Unfortunately, a definition of "identified" was not provided.

Guidance on this issue is of the utmost importance for healthcare providers given the Rule's FCA enforcement provision. The FCA permits the government to impose hefty penalties ranging from $5,500 to $11,000 per false claim and

[23] 42 U.S.C. § 1320a-7k(d) (2016).
[24] 31 U.S.C. § 3729(a)(1)(D) (2016).

up to treble total damages.[25] The FCA is invoked here through its "reverse" provision, which Congress introduced in 1986 with amendments to the FCA.[26]

Reverse false claims occur when a person knowingly avoids, conceals, or decreases an obligation to pay the government.[27] Courts struggled with how to define "obligation," with some circuits holding that an obligation could only exist through an independent legal duty to pay the government, and that simply making a false claim which *could* result in a penalty was not sufficient.[28] These decisions frustrated the FCA's enforcement, and in early 2009 the Department of Justice wrote Congress a letter stating that the courts "unduly narrowed the reverse false claim provision by holding or suggesting that the term obligation encompasses only a duty to pay that is fixed in all particulars, including the specific amount owed."[29]

Congress listened, and in April 2009 it passed the Fraud Enforcement and Recovery Act ("FERA") to combat fraud experienced during the housing crisis of 2008 and to

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[25] Federal Civil Penalties Inflation Adjustment Act of 1990, Pub. L .No. 101-410, § 5(a)(3), 104 Stat 890 (Jan. 5, 1990).

[26] James B. Helmer, Jr., *False Claims Act: Incentivizing Integrity for 150 Years for Rogues, Privateers, Parasites, and Patriots,* 81 U. Cin. L. Rev. 1261, 1272 (2013).

[27] 31 U.S.C. § 3729(a)(1)(G) (2009).

[28] *See* United States *ex rel.* Bahrani v. Conagra, Inc., 465 F.3d 1189, 1195 (10th Cir. 2006) (Tenth Circuit holding that an obligation arises from an independent legal duty and not from simply using or making a false record or statement that could result in a potential penalty); United States *ex rel.* Bain v. Ga. Gulf Corp., 386 F.3d 648, 658 (5th Cir. 2004) (Fifth Circuit holding that a chemical plant did not create a reverse false claim obligation when it falsified environmental emission reports because "the mere contingent potential that such fines or penalties might be… sought and imposed does not constitute an obligation…"); United States v. Q Int'l Courier, Inc., 131 F.3d 770, 774 (8th Cir. 1997) (Eighth Circuit holding that a courier service did not have a reverse false claims obligation for taking mail to Barbados and sending it back to the United States to save on postage costs because the penalties were potential and not "a fixed sum that is immediately due.").

[29] Letter from M. Faith Burton, Acting Assistant Att'y Gen., U.S. Dep't of Justice, to Sen. Patrick Leahy, Chairman, Senate Comm. on the Judiciary, (Feb. 24, 2009) *available at* http://www.friedfrank.com/files/QTam/DoJ%20Views%20on%20Section%204%20of%20FERA%20(2).pdf [perma.cc/VAJ6-Z668].

strengthen the FCA.[30] Senator Patrick Leahy, one of the bill's sponsors, declared that FERA "will rebuild the nation's capacity to investigate and prosecute the mortgage and corporate frauds that have so severely undermined the economy and hurt so many working people."[31] On the Senate floor, Senator Leahy spoke of the importance of updating the FCA and called it "one of the most potent civil tools we have for rooting out waste and fraud in government."[32] Reiterating the law's focus on the housing crisis, he said the "the False Claims Act must quickly be corrected and clarified in order to protect from fraud the Federal assistance and relief funds expended in response to our current economic crisis."[33]

In the House of Representatives, Dan Maffei of New York voiced prophetic concerns on the new reverse false claim provision's application to the medical field.[34] His speech shows that Congress contemplated the provision's effect on hospitals before deciding the changes would not unduly burden healthcare providers. His speech shows that Congress contemplated the provision's effect on hospitals before deciding the changes would not unduly burden healthcare providers. He stated,

> Drafting language to pursue unlawful retention of an overpayment proved difficult... When we considered similar legislation in committee, I learned that hospitals, universities, and other research institutions are among various entities that function in government programs where

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[30] Tyler Robinson & Roger R. Clayton, *Rise of the "Reverse" False Claim & Proposed Rules from CMS on Reporting & Returning Overpayments*, ILL. ASS'N DEF. OF COUNSEL QUARTERLY, (Jan. 9, 2014), http://www.iadtc.org/news/152147/Rise-of-the-Reverse-False-Claim--Proposed-Rules-from-CMS-on-Reporting--Returning-Overpayments.htm [perma.cc/LG6Q-EBPT].

[31] *Senate To Consider Leahy-Grassley Anti-Fraud Measure During Wednesday's Session*, OFF. OF SEN. PATRICK LEAHY (Apr. 22, 2009), http://www.leahy.senate.gov/press/senate-to-consider-leahy-grassley-anti-fraud-measure-during-wednesdays-session [perma.cc/NDA8-ZHPR].

[32] 111 Cong. Rec. S1682 (Feb. 5, 2009) (statement of Sen. Leahy).

[33] *Id.*

[34] 111 Cong. Rec. H5268 (May 6, 2009) (statement of H.R. Maffei).

> the program rules do require those entities to account for overpayments . . . .
> . . . A new subsection of the False Claims Act will not impose liability for the mere retention of an overpayment over the course of the reconciliation period. Rather, the new subsection would require proof of a knowing false record or statement, of knowing concealment, or of knowing and improper acts to avoid or decrease an obligation to pay money to the government.
> So, if a person or entity receives an overpayment from the United States and fails to return it immediately and instead takes steps to return the overpayment through an applicable reconciliation process, then liability would not attach. However, if a person falsifies information during a reconciliation period or otherwise acts knowingly and improperly to avoid the payment, liability would attach.
> So it's vitally important that we pass this legislation to fight financial fraud. But it's also important that we not punish universities, hospitals, and other important research institutions when they're doing everything that they are supposed to do. We must have enforcement and also fairness.[35]

Congress tailored the reverse false claim provision to healthcare institutions using the Rule. The Rule's addition of the sixty day clock shows Congress's intent to spur providers into action to repay obligations in a timely fashion. But Congress failed to shed adequate light on *when* a healthcare provider "identifies" an overpayment, and the S.D.N.Y. has adopted the government's position, which manifests Representative Maffei's warnings of the reverse false claims provision unduly burdening healthcare providers.

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[35] *Id.*

III. THE S.D.N.Y.'S FAULTY ANALYSIS

A. Plain Language Meaning

The S.D.N.Y. begins its analysis with the law's plain language, arguing that dictionaries do not resolve the questions of the meaning of "identified."[36] The court cites Black's Law Dictionary, which defines "identify" as "to prove the identity of."[37] Merriam-Webster's Dictionary defines "identify" as "to know and say who someone is or what something is," "to find out who someone is or what something is," and "to show who someone is or what something is."[38] The Oxford Dictionary offers, "to establish or indicate who or what someone or something is."[39] The court then turns to the "less prominent" Collins Dictionary which lists synonyms for "identify" as " 'recognize,' 'name,' 'pinpoint,' 'point out,' and 'spot.'"[40]

After listing these definitions, the court conclusorily states that "while Kane did not purport to conclusively prove the identity of any overpayments – and hundreds of the claims he listed had not actually been overpaid – he did 'recognize' nearly five hundred claims that did in fact turn out to have been overpaid as worthy of attention."[41] This conclusion appears to be derived from the list of synonyms in the Collins dictionary, conveniently ignoring the long list of definitions which give the real meaning of the word "identify." Looking through these definitions, the common thread is that something is not "identified" until someone can prove or show or what that thing is.

The analysis should have ended here, and the court should have determined that Kane's email did not identify any overpayments because the email did not prove or show funds received in error. Instead, the court moves on to an analysis of the Rule's legislative history to support its

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[36] Kane ex rel. U.S. v. Healthfirst, Inc., 120 F. Supp. 3d 370 (S.D.N.Y. 2015).

[37] *Id.* at 384.

[38] *Id.* at 384-85.

[39] *Id.* at 385.

[40] *Id.*

[41] *Id.*

position.[42] An overview of the Rule's development runs counter to the government and court's interpretation.

B. The Rule's Legislative Development

The Senate and House both worked on separate versions of the ACA for most of 2009.[43] The House chairmen working together on the ACA released the first House version of the health care legislation, called a "discussion draft," on June 19, 2009.[44] The purpose of this draft was to spur conversation to begin the legislative process in the House.[45] The Rule first appears here with the basic elements – reporting and returning overpayments – in place.[46]

However, this version of the Rule differs from the final one in several ways. The final Rule applies if "a person has received an overpayment," whereas the discussion draft version applies if "a person knows of an overpayment."[47] The discussion draft version's sixty day clock begins when an overpayment is "identified," much like the final Rule.[48] The two versions also state that overpayments kept beyond the sixty days become obligations under the FCA.[49] Absent from the discussion draft version is the clause tying the use of "knowing" or "knowingly" to the FCA definition (the "Definition Clause").[50]

After more hearings, the House Committee leaders introduced House Bill 3200, America's Affordable Health Choice Act of 2009, on July 14, 2009.[51] Traditionally House

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[42] *Id.* at 386.

[43] John Cannan, *A Legislative History of the Affordable Care Act: How Legislative Procedure Shapes Legislative History*, 105 LAW LIBR. J. 131, 145 (2013).

[44] *Id.* at 137.

[45] *Id.*

[46] *Id.*

[47] H.R. 3200, 111th Cong. at 725 (2009), *available at* https://www.gpo.gov/fdsys/pkg/BILLS-111hr3200ih/pdf/BILLS-111hr3200ih.pdf [perma.cc/2BLM-MM8E].

[48] *Compare* H.R. 3200 *with* 42 U.S.C. § 1320a-7k(d)(1) (2010).

[49] *Compare* H.R. 3200 *and* 42 U.S.C. § 1320a-7k(d)(1) (2010) *with* 31 U.S.C. § 3729 (2016).

[50] *Compare* H.R. 3200 *and* 42 U.S.C. § 1320a-7k(d)(1) (2010) *with* 31 U.S.C. § 3729 (2016).

[51] Cannan, *supra* note 43, at 137-38.

bills are crafted through a process where the Committee debates, amends, and then votes on whether or not to report out the bill.[52] Each amended version of the bill is known as a "markup" and is invaluable to a legal researcher for shedding light on amendments that were considered, debated, and discarded.[53] In the case of House Bill 3200, committee leadership instead drafted the bill behind closed doors and outside the markup process, leaving only its plain text as a guide.[54]

The House Bill 3200 version of the Rule altered the discussion draft version.[55] It kept the opening clause that the Rule applies if "a person knows of an overpayment," but changed the sixty day countdown's start from when the overpayment is "identified" to when "the person knows of the overpayment."[56] Along with this change, the House Bill 3200 version also introduced the Definition Clause defining "knows" as having the same meaning as "knowing and knowingly" from the FCA.[57]

The Senate Finance Committee also worked on a draft of the ACA during this time.[58] On September 16, 2009, Senator Baucus released his Chairman's mark of bill, called America's Healthy Future Act.[59] Undoubtedly the Finance Committee reviewed House Bill 3200, which was released two months before their version. This Senate version is written in a colloquial style, detailing the current status of the law and the proposed changes.[60] It states that the

> 60 days providers and suppliers have to repay Medicare overpayments would be modified to either 60 days after the date on which the

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[52] *Id.* at 138.

[53] *Id.*

[54] *Id.*

[55] America's Affordable Health Choices Act of 2009, 111th Cong., H.R.B 3200 (July 14, 2009), *available at* http://www.jeffhead.com/HC-HouseII.pdf [perma.cc/YTX8-N2HT].

[56] *Id.*

[57] *Id.* at 727.

[58] Cannan, *supra* note 43, at 147.

[59] *Id.*

[60] U.S. SENATE, COMMITTEE ON FINANCE, AMERICA'S HEALTHY FUTURE ACT OF 2009, S. DOC. NO. 111-89 (1st Sess. 2009).

> overpayment was made or the date the corresponding cost report is due. Providers and suppliers would be required to repay any Medicare or Medicaid overpayment identified through an internal compliance audit.[61]

Although it implies that the clock starts when an overpayment is made, much less identified or known, this mark was likely intended to foster discussion in anticipation of a heated legislative session and is not written in a legal manner.[62]

Back in the House, the Ways and Means Committee, the Committee on Education and Labor, and the Committee on Energy and Commerce conducted markups of House Bill 3200 in July 2009 and reported them to the House floor on October 14, 2009.[63] None of these markups changed the Rule's text.[64] House Bill 3200 ended with these three versions.[65]

Meanwhile, the Senate Finance Committee's markup sessions produced Senate Bill 1796, reported out on October 19, 2009.[66] Senate Bill 1796 contains the Rule in essentially its final form.[67] The only difference between the Senate Bill 1796 version and the final version, are clean-ups involving updating or clarifying internal citations such as changing a reference to "title XVIII" to "subchapter XVIII."[68]

The Senate made several changes to the House version of the Rule. First, the Senate changed the opening language from "if a person *knows* of an overpayment" to "if a person

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[61] *Id.*

[62] Cannan, *supra* note 43, at 147.

[63] *Id.* at 140.

[64] H.R. 3200, 111th Cong. at 725 (2009), *available at* https://www.gpo.gov/fdsys/pkg/BILLS-111hr3200ih/pdf/BILLS-111hr3200ih.pdf [perma.cc/2BLM-MM8E]; H.R. REP. NO. 111-299, pt. 1 (2009); H.R. REP. NO. 111-299, pt. 2 (2009) (note that the markup does not explicitly list the Rule but encompasses it because it says to keep Division B, which contained the Rule).

[65] Canaan, *supra* note 43, at 140.

[66] 111th CONG. SEN. FIN. COMM, S. 1796, Oct. 19, 2009.

[67] *Id.* at 1355-57.

[68] 42 U.S.C. § 1320a-7k(d) (2010).

has *received* an overpayment."[69] Importantly, it changed the clock's start to "the date on which the overpayment was identified" instead of "the date the person knows of the overpayment."[70] The most striking and confounding change that this Senate version produced from House Bill 3200 is that it removed all forms of the word "know" from the statute's text. However, it kept the Definition Clause and *even updated it* to now read "The terms 'knowing' and 'knowingly'" instead of "The term 'knows.'"[71]

A summary of the Rule's development is as follows:

[69] *Compare* 111th Cong. House Ways and Means Comm., H.R. 3200, (July 19, 2009), *with* 111th CONG. SEN. FIN. COMM., S. 1796, (Oct. 19, 2009).

[70] *Compare* 111th Cong. House Ways and Means Comm., H.R. 3200, (July 19, 2009), *with* 111th CONG. SEN. FIN. COMM., S. 1796, (Oct. 19, 2009).

[71] *Compare* 111th Cong. House Ways and Means Comm., H.R. 3200, (July 19, 2009), *with* 111th CONG. SEN. FIN. COMM., S. 1796, (Oct. 19, 2009).

	Discussion Draft	House Bill 3200	Senate Bill 1796
Opening	If a person knows of an overpayment	If a person knows of an overpayment	If a person has received an overpayment
Start of Clock	The date that is 60 days from the date the overpayment is identified	The date that is 60 days after the date the person knows of the overpayment	The date which is 60 days after the date on which the overpayment was identified
Definition Clause	N/A	The term 'knows' has the meaning given the terms 'knowing' and 'knowingly' in section 3729(b) of title 31 of the United States Code.	The terms 'knowing' and 'knowingly' have the meaning given those terms in section 3729(b) of title 31 of the United States Code.[72]

After a shorter review of the Rule's legislative history, the S.D.N.Y. acknowledged that Congress may have intended to impose a higher burden than the FCA knowing standard given its rejection of "knows" for "identified."[73] Yet the court also states that "it is equally plausible that Congress included the definitions of 'knowing' and 'knowingly' within the ACA's report and return provision in order to indicate

[72] *Compare* 111th Cong., *Discussion Draft*, (June 19, 2009), *available at* https://web.archive.org/web/20090624235405/http:/waysandmeans.house.gov/media/pdf/111/HRdraft1xml.pdf [perma.cc/MXM9-PQD2]; *with* H.R. 3200, 111th Cong. (Jul. 14, 2009); *as compared with* 1S. Res. 1796, (Oct. 19, 2009).

[73] Kane *ex rel.* U.S. v. Healthfirst, Inc., 120 F. Supp. 3d 370, 386 (S.D.N.Y. 2015).

that the FCA's knowledge standard should apply to the determination of when an overpayment is deemed 'identified.'"[74] The legislative history counters this assertion as it demonstrates that Congress is capable of providing definitions to words when it so intends.

C. The Rule's Plain Language Trumps the S.D.N.Y.'s Unsupported Policy Position

Admittedly, the court does not directly use the Definition Clause to provide its reasoning, although its conclusion comports with the FCA knowing standard. Instead, the court resorts to a general "policy" argument.[75] As recently seen in *King v. Burwell*, policy can play a strong role in the interpretation of the ACA.[76] The court harkens back to the reasoning behind FERA's passage. Congress updated the term "obligation" to include "an established duty, *whether or not fixed*, arising… from the retention of an overpayment."[77] Therefore, "Congress intended for FCA liability to attach in circumstances where, as here, there is an established duty to pay money to the government, even if the precise amount due has yet to be determined."[78] This logic ignores the fact that "overpayment" and "obligation" are not used synonymously in the Rule.

This nuance is crucial to understanding why the S.D.N.Y.'s position falls flat on its face, and why the definition of the word "overpayment" is just as critical as the word "identified." The clock starts with the identification of an "overpayment."[79] An overpayment is defined as "any funds that a person receives or retains … to which the person,

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[74] *Id.* at 387.

[75] *Id.* at 23.

[76] King v. Burwell, 135 S. Ct. 2480, 2496 (U.S. 2015) (stating that a policy goal of the Affordable Care Act is "to improve health insurance markets," therefore "[i]f at all possible, we must interpret the Act in a way that is consistent" with this goal). Notably, this case cited numerous examples of policy positions to support its claim, whereas here the record of policy statements on the Rule is barren.

[77] *Kane ex rel. U.S.,* 120 F. Supp. 3d 370, 388 (S.D.N.Y. 2015) (emphasis in original).

[78] *Id.* at 388.

[79] 42 U.S.C. § 1320a-7k(d) (2016).

after applicable reconciliation, is not entitled."[80] An overpayment becomes a reverse false claims obligation after sixty days.[81] Therefore, an overpayment cannot exist unless funds have been received and retained, and an obligation cannot exist without an overpayment. How, then, can Kane's spreadsheet identify any overpayments when the list does not state the corresponding funds received for each claim?

The clear answer is that it cannot. By the court's own admission, "approximately half of the claims listed therein were never actually overpaid."[82] If no excess funds were received, there was no overpayment, and no overpayment means no obligation. There is no dispute that an exact dollar amount need not be pre-determined for an obligation to exist. But by the same token, an obligation under the Rule cannot exist when the existence of an overpayment is unknown.

D. Creating Absurdity Where None Exists

The court makes the case that its interpretation avoids the "absurdity" that comes with the plain language meaning of the Rule.[83] This reading, the court argues, "would make it all but impossible to enforce the reverse false claims provision of the FCA in the arena of healthcare fraud" because providers would intentionally bury their heads in the sand.[84] Without holding that Kane's email identified overpayments, "there will be no recourse for the Government when providers behave as Continuum allegedly behaved here."[85] One would be hard pressed to find a provider that argues that it is allowed to hold onto overpayments, given that the Rule did not replace the FCA. Retaining funds to which the person is not entitled is still an illegal act.

When viewed with the realities of a provider's internal Medicare and Medicaid audit process, the Rule is not absurd. The defense described the process to the court's deaf ears, noting that once a provider is made aware of a potential

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[80] *Id.* at § 1320a-7k(d)(4)(B).
[81] *See id.* at § 1320a-7k(d)(2).
[82] *Kane ex rel. U.S.*, 120 F. Supp. 3d 370, 388 (S.D.N.Y. 2015).
[83] *Id.* at 389.
[84] *Id.* at 390.
[85] *Id.*

overpayment it must pull and review the relevant medical records, discuss the cases with the physicians, consult with coding staff and possibly counsel, and then expand the scope of the audit if the initial sample reveals overpayments.[86] The provider then makes arrangements to return the overpayments which may involve identifying every specific claim that resulted in an overpayment.[87]

Applied as written, the Rule gives providers a hard deadline of sixty days to return the overpayments that are identified once funds are matched to claims in the audit process. This would ensure that overpayments continuously and timely roll to Medicare Administrative Contractors while the provider conducts the audit. This standard would establish a level of predictability for providers and their Medicare Administrative Contractors for the backwards flow of money. The "absurdity" the court warns will consume the industry is not apparent.

IV. CONCLUSION

The court stretches the language of the statute beyond what it can bear in order to satisfy the government's hindsight-driven argument. It is disheartening that the court did not take the opportunity to interpret the law as it is written. Such a holding, if not what the legislature intended, would spur Congress to reexamine the poorly-written statute. Hearings on the Rule attended by compliance officers and other deep in the trenches would teach Congress the operations of a provider's reimbursement process.

Returning Medicare and Medicaid overpayments is an extremely important policy goal for the Office of Inspector General and the Department of Justice. Those charged with protecting the Medicare Trust Fund must have the proper tools to fulfill their mission, and conscripting providers to timely return overpayments will free the government's already thin resources. But the enforcers must stay within the law. The government rightfully argues that failing to

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[86] *Id.* at 388-389 (quoting Mem. of Law in Support of Defendant's Mot. to Dismiss Gov't. Compl. at 10–11, Kane v. Healthfirst, Inc., No. 11 Civ. 2325 (ER) (S.D.N.Y. Sept. 22, 2014)).

[87] *Id.* at 389.

return the overpayment by day sixty-one does not automatically mean that the provider will be hauled to court, stating at a pre-motion conference that if "the hospital is diligently working on the claims and it's on the sixty-first day . . . the government wouldn't be bringing that kind of a claim."[88]

As shown above, it is questionable if the government could even bring a claim if no overpayment exists. But assuming the government's position prevails, is constantly hanging the Sword of Damocles over the heads of the nation's hospitals a good policy goal? By ensuring that healthcare providers will be in an eternal state of panic, the S.D.N.Y. is securing employment for audit consulting firms for years to come. Hospitals that do not have the finances to hire a legion of CPAs or consultants must either fold or rely on the mercy of government attorneys such as the one who promised they "wouldn't be bringing that kind of a claim."[89]

On February 12, 2016, the Centers for Medicare & Medicaid Services (CMS) released its final rule on the 60 Day Report and Return Rule's applicability to Medicare Parts A and B.[90] Relevant to this discussion, the final rule states that an overpayment is "identified" when the person "has, or should have through the exercise of reasonable diligence, determined that the person received an overpayment and quantified the amount of the overpayment." [91] This is a welcome departure from using the False Claims Act knowing standard. However, only through future enforcement will we have a clearer picture of what this test means. The *Kane* statutory analysis remains relevant in the event that the CMS Final Rule fails to withstand judicial scrutiny.

Going forward, providers will operate under the "reasonable diligence" test. CMS states that "reasonable diligence" captures both proactive and reactive solutions including timely investigations in response to credible

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[88] *Id.* at 389-90 (quoting Transcript of Record at 22:8-12, Kane v. Healthfirst, Inc., No. 11 Civ. 2325 (ER) (S.D.N.Y. Sept. 5, 2014).

[89] *Id.*

[90] Medicare Program; Reporting and Returning of Overpayments, 81 Fed. Reg. 7654 (Feb. 12, 2016) (to be codified at 42 C.F.R. pts. 401 and 405).

[91] 42 C.F.R. § 401.305 (2016).

information of a potential overpayment.[92] Applied to *Ex Rel Kane*, the defendants would likely run afoul of exercising "reasonable diligence" given that it took more than two years to repay the full amount and only after repeated requests for information.

Despite CMS's improvements, the statute's sixty day time limit will continue to weigh on the nation's healthcare providers. The law will likely produce its intended effect to spur proactive compliance departments, but the price may outweigh its benefits. Perhaps instead of the "report *and* return rule," the Rule should be the "report *then* return rule" with the clock's length determined by the scope of the potential overpayment. Were this the Rule when Continuum received Kane's email, Continuum could have reported the potential overpayment to the government. The government would have then determined the amount of time to return any identified overpayments based on the number of questionable claims and possible dollar amount.

The final rule allows for extended repayments under the existing Extended Repayment Schedule program, but a provider must show financial hardship in terms of repaying an identified overpayment and not because of the demands of internal investigations.[93] With the hard wall of sixty days, compliance departments will need to hire and train enough employees to respond in full force to even the slightest scent of smoke. These costs will be passed on to taxpayers and patients through increased hospital charges until Congress takes the initiative to amend the Rule to reflect reality.

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[92] Medicare Program; Reporting and Returning of Overpayments, 81 Fed. Reg. 7661.

[93] Medicare Program; Reporting and Returning of Overpayments, 81 Fed. Reg. at 7679, 7684.