WRONGLY "IDENTIFIED": WHY AN ACTUAL KNOWLEDGE STANDARD SHOULD GOVERN HEALTH CARE PROVIDERS' FALSE CLAIMS ACT OBLIGATIONS TO REPORT AND RETURN MEDICARE AND MEDICAID OVERPAYMENTS

INTRODUCTION

In 2015, Medicare spent $632 billion on health care for America's elderly (and other covered groups).[1] Medicaid spent another $554 billion to provide health care to America's needy.[2] The government estimates that

1. JULIETTE CUBANSKI & TRICIA NEUMAN, KAISER FAMILY FOUND., THE FACTS ON MEDICARE SPENDING AND FINANCING 1 (2016), http://files.kff.org/attachment/Issue-Brief-The-Facts-on-Medicare-Spending-and-Financing. This $632 billion total was about 15% of the 2015 federal budget. *Id.* Medicare is a government program, administered by the Centers for Medicare & Medicaid Services, the primary function of which is to provide health insurance to people age 65 or older. *Medicare Program—General Information*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://www.cms.gov/medicare/medicare-general-Information/medicareGenInfo/index.html (last visited Feb. 10, 2017). It also covers people younger than 65 with certain disabilities, as well as anyone with end-stage renal disease. *Id.* Medicare has four parts: A, B, C, and D. Broadly speaking, Part A covers inpatient services (*i.e.*, those requiring admission to a hospital), while Part B provides coverage for outpatient care. *See* David Blumenthal, Karen Davis & Stuart Guterman, *Medicare at 50—Origins and Evolution*, 372 NEW ENG. J. MED. 479, 480 (2015). Part A covers things like hospital care, skilled nursing facility care, nursing home care, hospice, and home health services. *What Part A Covers*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://www.medicare.gov/what-medicare-covers/part-a/what-part-a-covers.html (last visited Feb. 10, 2017). Part B covers clinical research, ambulance services, durable medical equipment, mental health care, second opinions before surgery, and limited outpatient prescription drugs. *What Part B Covers*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://www.medicare.gov/what-medicare-covers/part-b/what-medicare-part-b-covers.html (last visited Feb. 10, 2017). Part C allows those enrolled in Parts A and B to enroll in certain Medicare-approved private health insurance plans (known as "Medicare Advantage" plans). *How Do Medicare Advantage Plans Work?*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://www.medicare. gov/sign-up-change-plans/medicare-health-plans/medicare-advantage-plans/how-medicare-advantage-plans-work.html (last visited Feb. 10, 2017). Part D provides prescription drug coverage. *Drug Coverage (Part D)*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://www.medicare.gov/part-d/index.html (last visited Feb. 10, 2017).

2. This figure is based on the Centers for Medicare & Medicaid Services' estimate for fiscal year 2015. CTRS. FOR MEDICARE & MEDICAID SERVS., 2015 ACTUARIAL REPORT ON THE FINANCIAL OUTLOOK FOR MEDICAID 15 (2015), https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/MedicaidReport2015.pdf. Medicaid is "a joint state-federal program in which healthcare providers serve poor or disabled patients and submit claims for government reimbursement." Universal Health Servs., Inc. v. United States *ex rel.* Escobar, 136 S. Ct. 1989, 1996–97 (2016). Under the program, states pay "health care providers for services rendered to Medicaid recipients," Kane *ex rel.* United States v. Healthfirst, Inc., 120 F. Supp. 3d 370, 375 n.3 (S.D.N.Y. 2015), and the federal government then provides states with matching funds. *See* KAISER FAMILY FOUND., MEDICAID: AN OVERVIEW OF SPENDING ON "MANDATORY" VS. "OPTIONAL" POPULATIONS AND SERVICES 1 (2005), http://www.kaiserfamilyfoundation.files.wordpress.com/2013/01/medicaid-an-overview-of-spending-on.pdf. To participate in Medicaid, states must cover certain "mandatory" beneficiaries. They may also choose to cover other "optional" beneficiaries. *Id.* at

improper payments account for as much as 10% of Medicare and Medicaid spending.[3] Given the vast amount of money at stake, and the fact that there is bipartisan support for recovering taxpayer dollars,[4] it is no surprise the federal government has made it a priority to recoup the money lost to health care fraud each year.[5] The results are noticeable: annual recoveries for health care fraud through the federal government's most powerful anti-fraud weapon, the False Claims Act (FCA or "the Act"),[6] have increased from $932 million in 2000 to a high-water mark of more than $3 billion in 2012.[7]

1–3. In general, mandatory beneficiaries include low-income children and parents, the low-income elderly, and the low-income disabled. *Id.* at 1–2. Optional beneficiaries largely come from these same groups, but have incomes above the threshold for mandatory coverage. *Id.* at 2–3. Those states that accepted the Affordable Care Act's Medicaid expansion must now cover "all individuals under the age of 65 with incomes below 133 percent of the federal poverty line." Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2601 (2012) (emphasis deleted) (citing 42 U.S.C. § 1396a(a) (10)(A)(i)(VIII) (2012)).

3. U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-15-448, MEDICARE PROGRAM: ADDITIONAL ACTIONS NEEDED TO IMPROVE ELIGIBILITY VERIFICATION OF PROVIDERS AND SUPPLIERS 1 (2015) (citing an estimate by the Centers for Medicare & Medicaid Services that improper payments accounted for 10.8% of Medicare spending in 2014), http://www.gao.gov/assets/680/671021.pdf; U.S. DEP'T OF HEALTH & HUMAN SERVS. & CTRS. FOR MEDICARE & MEDICAID SERVS., HEALTH CARE FRAUD AND PROGRAM INTEGRITY: AN OVERVIEW FOR PROVIDERS 2–3 (2016) (citing an estimate by the United States Office of Management and Budget that the improper payment rate for Medicaid in 2015 was 9.78%), https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/ Medicaid-Integrity-Education/Downloads/fwa-overview-booklet.pdf. Professor Malcolm Sparrow has put the figure even higher, at 10–20%. *Criminal Prosecution as a Deterrent to Health Care Fraud: Hearing Before the Subcomm. on Crime and Drugs of the S. Comm. on the Judiciary*, 111th Cong. 13 (2009) (statement of Malcolm Sparrow, Professor, Harvard University John F. Kennedy School of Government).

4. *See* Timothy Stoltzfus Jost & Sharon L. Davies, *The Empire Strikes Back: A Critique of the Backlash Against Fraud and Abuse Enforcement*, 51 ALA. L. REV. 239, 239–40 (1999); Joan H. Krause, *Health Care Providers and the Public Fisc: Paradigms of Government Harm Under the Civil False Claims Act*, 36 GA. L. REV. 121, 124 (2001) ("[A]nti-fraud rhetoric now pervades the national health care debate, with health care providers joining Cadillac-driving 'welfare queens' and $400 hammers as the subjects of apocryphal tales of government fraud."); William M. Sage, *Fraud and Abuse Law*, 282 JAMA 1179, 1180 (1999) (stating that, when it comes to reducing health care spending, "eliminating 'waste, fraud, and abuse' is [one] of the few steps about which disparate political ideologies can agree"); Joseph W. Golinkin II, Note, *Fishing with Landmines: Healthcare Fraud and the Civil False Claims Act—Where We Are, How We Got Here, and the Case for More Trials*, 40 AM. J. CRIM. L. 301, 302 (2013) ("[H]ealthcare fraud [is] one of the few subjects upon which policymakers from both major political parties can agree.").

5. *See* Paul E. Kalb, *Health Care Fraud and Abuse*, 282 JAMA 1163, 1163 (1999) (stating that the Department of Justice has made health care fraud its second-highest priority behind only violent crime); Stephanie Armour, *U.S. Recovers $3.3 Billion in Federal Health-Care Fraud; Obama Administration Steps up Efforts to Prevent Medicare Fraud, not Just Uncover It*, WALL ST. J. (Mar. 19, 2015) (noting that "[t]he Obama Administration has been intensifying its focus on fraud and waste"), http://www.wsj.com/articles/u-s-recovers-3-3-billion-in-federal-health-care-fraud-1426737703; Press Release, Dep't of Justice, Health Care Fraud Prevention and Enforcement Efforts Result in Record-breaking Recoveries Totaling Nearly $4.1 Billion (Feb. 14, 2012), http://www.justice.gov/opa/pr/health-care-fraud-prevention-and-enforcement-efforts-result-record-breaking-recoveries.

6. 31 U.S.C. §§ 3729–3733 (2012).

7. *Fraud Statistics—Health and Human Services: Oct. 1, 1987–Sept. 30, 2015*, U.S. DEP'T OF JUSTICE, CIVIL DIV., https://www.justice.gov/opa/file/796866/download (Nov. 23, 2015) [hereinafter

Health care providers now pay millions of dollars to settle allegations that they have committed health care fraud in violation of the FCA.[8]

Among the anti-fraud laws at the government's disposal, the FCA is the most imposing. Congress has described it as "one of the most potent civil tools for rooting out waste and fraud in Government."[9] Today, it has become the government's "favorite weapon" to turn on health care fraud,[10] and "has grown to assume almost mythical proportions in the fight against health care fraud."[11] One reason the FCA is so valuable to the government, and "a modern nightmare for the health care industry,"[12] is that it carries the potential for especially large liability.[13] Sanctions for violating the Act include treble damages[14] and penalties of up to $21,563 per individual false

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DOJ, Fraud Statistics—Health and Human Services]. In 2015, the most recent year for which data are available, DOJ recovered $1.965 billion in health care fraud cases brought under the FCA. *Id.* This is down from $2.4 billion in 2014 and $2.7 billion in 2013. *Id.*

8. *See, e.g.*, Patricia Meador & Elizabeth S. Warren, *The False Claims Act: A Civil War Relic Evolves into a Modern Weapon*, 65 TENN. L. REV. 455, 470 (1998) (providing examples of FCA health care settlements for $379 million, $255 million, and $182 million); Press Release, Dep't of Justice, Adventist Health System Agrees to Pay $115 Million to Settle False Claims Act Allegations (Sept. 21, 2015), http://www.justice.gov/opa/pr/adventist-health-system-agrees-pay-115-million-settle-false-claims-act-allegations; Press Release, Dep't of Justice, Minnesota-Based Hospice Provider to Pay $18 Million for Alleged False Claims to Medicare for Patients Who Were Not Terminally Ill (July 13, 2016), https://www.justice.gov/opa/pr/minnesota-based-hospice-provider-pay-18-million-alleged-false-claims-medicare-patients-who; Press Release, Dep't of Justice, Nearly 500 Hospitals Pay United States More than $250 Million to Resolve False Claims Act Allegations Related to Implantation of Cardiac Devices (Oct. 30, 2015), http://www.justice.gov/opa/pr/nearly-500-hospitals-pay-united-states-more-250-million-resolve-false-claims-act-allegations; Press Release, Dep't of Justice, South Carolina Hospital to Pay $17 Million to Resolve False Claims Act and Stark Law Allegations (July 28, 2016), https://www.justice.gov/opa/pr/south-carolina-hospital-pay-17-million-resolve-false-claims-act-and-stark-law-allegations.

9. S. REP. NO. 111-10, at 4 (2009), *reprinted in* 2009 U.S.C.C.A.N. 430, 433.

10. Meador & Warren, *supra* note 8, at 456.

11. Joan H. Krause, *"Promises to Keep": Health Care Providers and the Civil False Claims Act*, 23 CARDOZO L. REV. 1363, 1415 (2002).

12. Meador & Warren, *supra* note 8, at 456.

13. *See id.* ("The False Claims Act is notable for its harsh penalties and damage provisions."). *United States v. Lorenzo*, 768 F. Supp. 1127 (E.D. Pa. 1991), illustrates the rate at which the FCA can magnify liability in the health care arena. In that case, the defendant was a Philadelphia dentist who improperly billed Medicare 3,683 times for oral cancer screenings that he performed during standard dental examinations. *Id.* at 1129. From these claims, the dentist received $130,719.10. *Id.* The court awarded the United States $392,157.30 in treble damages, along with $18,415,000 in penalties (the defendant made 3,683 individual false claims, multiplied by the $5,000 per claim minimum penalty). *Id.* at 1133. In other words, the total monetary sanctions assessed against the dentist in this case equaled more than 140 times the amount of improper payments that he actually received from Medicare. *See also* Adam G. Snyder, *The False Claims Act Applied to Health Care Institutions: Gearing Up for Corporate Compliance*, 1 DEPAUL J. HEALTH CARE L. 1, 8–9 (1996) (discussing the *Lorenzo* case and referring to it as a "classic False Claims action").

14. 31 U.S.C. § 3729(a)(1) (2012) (A person who violates the FCA is liable for "3 times the amount of damages which the Government sustains because of the act of that person[.]").

claim.[15] Of even greater concern to the health care community, the United States Department of Health and Human Services may also exclude providers who violate the FCA from future participation in Medicare and Medicaid.[16] Since providers depend on these programs for a sizable portion of their overall revenues,[17] they have particular reason to fear exclusion.[18] Another powerful feature of the Act is its relatively unusual *qui tam* mechanism, whereby any private individual who becomes aware of fraud can bring suit on behalf of the government and recover a portion of the government's award.[19] Thus, even if the government does not know about a particular incident of health care fraud, the FCA's *qui tam* function monetarily incentivizes any private individual who *does* know about it to come forward and sue the alleged fraudster. And in addition to the federal Act, in a majority of states providers may face prosecution under a state law version of the FCA too.[20]

One way a health care provider can violate the FCA is to retain payments from Medicare or Medicaid to which the provider is not legally entitled.[21] Medicare and Medicaid work by reimbursing health care providers for services performed based on an established fee schedule.[22] Providers submit

15. 28 C.F.R. § 85.5 (2016). For more on the size of penalties under the Act, see *infra* note 66.

16. *See* 42 U.S.C. § 1320a-7b(a) (2012); Golinkin II, *supra* note 4, at 302.

17. In 2006, Medicare payments accounted for 31% of the net revenues of U.S. hospitals. Uwe E. Reinhardt, *The Pricing of U.S. Hospital Services: Chaos Behind a Veil of Secrecy*, 25 HEALTH AFF. 57, 59 (2006).

18. *See* Golinkin II, *supra* note 4, at 302 (describing exclusion from Medicare and Medicaid as a "death sentence" for health care providers); David Freeman Engstrom, *Public Regulation of Private Enforcement: Empirical Analysis of DOJ Oversight of Qui Tam Litigation Under the False Claims Act*, 107 NW. U. L. REV. 1689, 1713 (2013) (same).

19. *See* 31 U.S.C. § 3730 (2012). For more on the Act's *qui tam* function, see *infra* notes 56–62 and accompanying text.

20. Following the federal government's lead, twenty-one states plus the District of Columbia have passed their own generally applicable versions of the FCA. Another eight have created "Medicaid only" false claims acts. *States with False Claims Acts*, TAXPAYERS AGAINST FRAUD EDUC. FUND, http://www.taf.org/states-false-claims-acts (last visited Feb. 10, 2017). In some states, the penalties are more onerous than under the federal FCA. For example, the Tennessee Medicaid False Claims Act allows treble damages plus penalties of up to $25,000 per claim. TENN. CODE ANN. § 71-5-182(a)(1) (2016). State and federal governments may each seek penalties and damages for the same false claims. For instance, in *Kane ex rel. United States v. Healthfirst, Inc.*, 120 F. Supp. 3d 370, 379 (S.D.N.Y. 2015), discussed *infra* in Part II, the United States sought treble damages plus an $11,000 penalty per false claim, while New York State sought treble damages plus $12,000 for each false claim. In addition to state false claims acts, New York City and Chicago also have their own municipal false claims statutes. *Practice Tool 18 Survey of State False Claims Statutes with Qui Tam Provisions* 3, 5 (Bloomberg Law Portfolio 2650: False Claims Act: Health Care Applications and Defense, Working Paper), https://www.bloomberglaw.com/p/f90d8eac6ac34a9d780d0fee47e0b7c6/document/2760181288.

21. *See* 31 U.S.C. § 3729(a)(1)(G), (b)(3) (2012); 42 U.S.C. § 1320a-7k(d) (2012). The details of how retention of Medicare or Medicaid overpayments can develop into FCA liability are discussed *infra* in Parts I.B and I.C.

22. *See* Blumenthal, Davis & Guterman, *supra* note 1, at 482; Allan S. Brett, *New Guidelines for*

codes describing the services they have rendered, and Medicare or Medicaid reimburses the appropriate amount.[23] If a provider submits the wrong code, it may receive more money than it is legally entitled to.[24] When providers do this intentionally, it is known as "upcoding."[25] However, even if a provider is overpaid accidentally, once it realizes the mistake it violates the FCA unless it reports and returns the overpayment within a certain period of time.

There is no doubt that intentional upcoding is a form of fraud. Similarly, it is clear that health care providers who realize they have been overpaid should return the money as soon as feasible. However, providers may not always know when they have been overpaid for the simple reason that correctly billing a Medicare or Medicaid claim can be quite difficult. Medicare in particular is, "to say the least, a complicated program."[26] The Medicare statute is more than 400 pages long, and its implementing regulations require another "1200 dense Code of Federal Regulations

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Coding Physicians' Services—A Step Backward, 339 NEW ENG. J. MED. 1705, 1705 (1998).

23. *See* Peter J. Carpentier, Note, *The Risk of Getting Paid: Why ICD-10-CM May Increase Physician Liability Under the False Claims Act*, 16 QUINNIPIAC HEALTH L.J. 117, 120 (2013); United States v. Lakeshore Med. Clinic, Ltd., No. 11-CV-00892, 2013 WL 1307013, at *2 (E.D. Wis. Mar. 28, 2013) (explaining the Medicare and Medicaid coding process). Technically, providers submit their Medicare claims to private contractors, who then reimburse the providers on behalf of Medicare. *See* New Eng. Deaconess Hosp. v. Sebelius, 942 F. Supp. 2d 56, 57–58 (D.D.C. 2013). As for Medicaid, states initially reimburse providers; then, the federal government partially reimburses the states for a portion of the fee, ranging from 50–74% depending on the state. THE PEW CHARITABLE TRUSTS & THE JOHN D. & CATHERINE T. MACARTHUR FOUND., STATE HEALTH CARE SPENDING ON MEDICAID 2 fig. 1 (2014), http://www.pewtrusts.org/~/media/data-visualizations/interactives/2014/medicaid/downloadables/state_health_care_spending_on_medicaid.pdf.

24. Since the 1980s, American health care providers have used a coding system called ICD-9. Carpentier, *supra* note 23, at 122. The World Health Organization has recently introduced a new coding system, ICD-10, which includes far more specific codes than the old system. *Id.* at 122–23. As of October 1, 2015, the Centers for Medicare & Medicaid Services requires providers to use ICD-10. R.J. Petrella, Opinion, *Medical Query: Were You Struck by a Duck?*, WALL ST. J. (Oct. 13, 2015), http://www.wsj.com/articles/medical-query-were-you-struck-by-a-duck-1444776711. Among the roughly 70,000 codes included in ICD-10 are such amusingly hyper-specific ones as "struck by a duck," "sucked into a jet engine," and "burn due to water-skis on fire." *Id.* Other absurdly specific codes include: "struck by orca, initial encounter"; "prolonged stay in weightless environment"; "passenger in heavy transport vehicle injured in collision with pedal cycle in traffic accident"; "bizarre personal appearance"; "hit or struck by falling object due to accident to merchant ship, initial encounter"; and "other contact with shark." STRUCK BY ORCA: ICD-10 ILLUSTRATED (Niko Skievaski, ed. 2014). With this proliferation of new codes, providers have more opportunities to inadvertently select the wrong one. *See* Carpentier, *supra* note 23, at 138–39.

25. *See, e.g.*, United States *ex rel.* Thayer v. Planned Parenthood of the Heartland, 765 F.3d 914, 916 (8th Cir. 2014).

26. Caring Hearts Pers. Home Servs., Inc. v. Burwell, 824 F.3d 968, 970 (10th Cir. 2016) (Gorsuch, J.). For reasons why providers complain that Medicare is too complex, see Jost & Davies, *supra* note 4, at 261–64.

pages."[27] The Supreme Court has called Medicare a "massive, complex health and safety program . . . embodied in hundreds of pages of statutes and thousands of pages of often interrelated regulations,"[28] while a district court has referred to the Medicare statute as "convoluted and complex" and a "model of *un*-clarity."[29] One commentator has called Medicare's regulatory complexity "unrivaled anywhere in the world," and noted that its regulations outnumber even those of the labyrinthine Internal Revenue Code.[30] Perhaps in part because of this regulatory complexity, Medicare overpayments are far from uncommon: in fiscal year 2014 alone, the Recovery Audit Program discovered more than one million improper Medicare claims resulting in $2.39 billion in overpayments nationwide.[31] The previous year nearly 1.5 million improper Medicare claims led to $3.65 billion in overpayments.[32] While some of these improper claims may have been intentionally fraudulent, others were likely caused by "the complexity of the Medicare maze."[33]

As part of the Affordable Care Act (ACA),[34] Congress enacted the so-called "Sixty-Day Rule,"[35] which requires providers to report and return all overpayments from Medicare or Medicaid within sixty days of when the

27. Jost & Davies, *supra* note 4, at 262.

28. Shalala v. Ill. Council on Long Term Care, Inc., 529 U.S. 1, 13 (2000). *See also* Shalala v. Guernsey Mem'l Hosp., 514 U.S. 87, 101 (1995) (referring to the "complex Medicare reimbursement process"); Fischer v. United States, 529 U.S. 667, 683 (2000) (Thomas, J., dissenting) ("[T]he Medicare reimbursement scheme is quite complex . . . .").

29. Estate of Urso v. Thompson, 309 F. Supp. 2d 253, 259 (D. Conn. 2004).

30. Uwe E. Reinhardt, Opinion, *Medicare Can Turn Anyone Into a Crook*, WALL ST. J. (Jan. 21, 2000), http://www.wsj.com/articles/SB948408802553884631.

31. CTRS. FOR MEDICARE & MEDICAID SERVS., RECOVERY AUDITING IN MEDICARE FOR FISCAL YEAR 2014 13 tbl. 1 (2014), https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/RAC-RTC-FY2014.pdf. The National Recovery Audit Program is overseen by the Centers for Medicare & Medicaid Services. *Id.* at iv. Its purpose is "to identify and correct Medicare and Medicaid improper payments." *Id.* Individual audits in the program are conducted by private contractors known as Recovery Audit Contractors. *Id.* In 2014, the Recovery Audit Program also identified $173.1 million in underpayments that were subsequently given to providers. *Id.* at 13.

32. CTRS. FOR MEDICARE & MEDICAID SERVS., RECOVERY AUDITING IN MEDICARE FOR FISCAL YEAR 2013 11 tbl. 1 (2013), https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/FY-2013-Report-To-Congress.pdf.

33. Caring Hearts Pers. Home Servs., Inc. v. Burwell, 824 F.3d 968, 970 (10th Cir. 2016) (Gorsuch, J.). *See also* Reinhardt, *supra* note 30 (arguing that, like the Internal Revenue Code, Medicare's complexity "has the capacity to criminalize the behavior of perfectly decent citizens who would never willfully break rules, if they understood them").

34. 42 U.S.C. §§ 18001 *et seq.* (2012).

35. For convenience, I refer to 42 U.S.C. § 1320a-7k(d)(2)–(d)(3) (2012) collectively as the "Sixty-Day Rule," although this is not an official name.

overpayments are "identified."[36] Otherwise, the provider risks violating the FCA.[37] However, the Sixty-Day Rule does not explain what it means for a particular overpayment to be "identified,"[38] thus leaving it to the Centers for Medicare & Medicaid Services (CMS) to flesh out the precise meaning of that term.[39]

A hospital submitting a large volume of Medicare and Medicaid claims is nearly certain to receive overpayments. For example, consider the results of three recent audits of prominent teaching hospitals, each involving Medicare claims selected because they were at risk for billing errors. First, in an audit of 240 Medicare Part A and B claims submitted by St. Louis's Barnes Jewish Hospital[40] primarily between 2009 and 2010, the Office of Inspector General (OIG) found that 58 claims had been overpaid, resulting in $725,185 in overpayments to the hospital.[41] A similar audit at Chicago's Northwestern Memorial Hospital[42] revealed that 85 out of 171 Medicare claims sampled there were overpaid in 2011 and 2012, causing Medicare to overpay the hospital by $272,181.[43] Finally, an audit of Medicare Part A and B claims submitted by Mary Hitchcock Memorial Hospital[44] from 2009

36. 42 U.S.C. § 1320a-7k(d)(2).

37. *See* 42 U.S.C. § 1320a-7k(d)(3). Specifically, the provider may be liable for a so-called "reverse false claim" under 31 U.S.C. § 3729(a)(1)(G). The concept of a reverse false claim is explained *infra* in the text accompanying notes 85–90. Parts I.B and I.C., *infra*, elaborate further on how a provider violates the FCA by retaining Medicare or Medicaid overpayments.

38. *See* Kane *ex rel.* United States v. Healthfirst, Inc., 120 F. Supp. 3d 370, 381 (S.D.N.Y. 2015) ("Congress did *not* define the pivotal word 'identified,' which triggers the sixty-day report and return clock, in the text of the ACA.").

39. *See* Chevron, U.S.A., Inc. v. NRDC, 467 U.S. 837, 843–44 (1984) (explaining that if a statute is "ambiguous with respect to [a] specific issue," courts should treat this as an implicit "legislative delegation" of that issue to the agency responsible for administering the statute). CMS is the executive agency charged with "administering the Medicare program and administering the Medicaid program in partnership with state governments." *Healthfirst,* 120 F. Supp. 3d at 391 (citing 42 U.S.C. §§ 1395, 1396).

40. Barnes Jewish is an affiliated teaching hospital of Washington University School of Medicine. *About Us*, BARNES JEWISH HOSP., http://www.barnesjewish.org/About-Us (last visited Feb. 10, 2017).

41. U.S. DEP'T OF HEALTH & HUMAN SERVS., OFFICE OF INSPECTOR GENERAL, A-07-11-05014, MEDICARE COMPLIANCE REVIEW OF BARNES JEWISH HOSPITAL FOR CALENDAR YEARS 2009 AND 2010 4 (2012), http://oig.hhs.gov/oas/reports/region7/71105014.pdf. Barnes Jewish submitted more than 300,000 claims under Medicare Parts A and B in the period covered by the audit. *Id.* at 3. OIG selected the 240 audited claims because they were "potentially at risk for billing errors." *Id.*

42. Northwestern Memorial is the 894-bed primary teaching hospital for Northwestern University's Feinberg School of Medicine. It submitted more than 250,000 Medicare Part A and B claims during the relevant period. U.S. DEP'T OF HEALTH & HUMAN SERVS., OFFICE OF INSPECTOR GENERAL, A-05-13-00051, MEDICARE COMPLIANCE REVIEW OF NORTHWESTERN MEMORIAL HOSPITAL FOR 2011 AND 2012 3 (2015), http://oig.hhs.gov/oas/reports/region5/51300051.pdf.

43. *Id.* OIG randomly selected the 171 audited claims from a larger group of 7,506 claims it had identified as "potentially at risk for billing errors." *Id.*

44. A 396-bed teaching hospital located in Lebanon, NH and affiliated with Dartmouth College's Geisel School of Medicine, Mary Hitchcock Memorial is part of the Dartmouth-Hitchcock Health

to 2012 revealed overpayments on 255 out of 445 sampled claims, totaling $770,735 in overpayments.[45]

Consider the tremendous liability these hospitals could have faced if, hypothetically, a court was to determine they had "identified" these overpayments at some point more than sixty days before the OIG audits. To take the most extreme case, OIG's audit of Mary Hitchcock found that 255 out of 445 audited Medicare claims were improperly submitted, causing the government to overpay Mary Hitchcock by $770,735.[46] If Mary Hitchcock retained this money for more than sixty days after "identifying" it, these overpayments might have cost the hospital $2,312,205 in FCA treble damages.[47] On top of that, Mary Hitchcock might also have owed up to $21,563 in penalties *per overpaid claim*.[48] If the maximum penalty were assessed for all 255 overpaid claims, Mary Hitchcock would have owed $5,498,565 in additional penalties, bringing the grand total to $7,810,770.[49] Of even more concern to Mary Hitchcock, it might also have faced exclusion from future participation in Medicare.[50] In fact, Mary Hitchcock faced none of these sanctions—OIG merely recommended that the hospital refund the overpayments discovered by the audit and "strengthen controls to ensure full compliance with Medicare requirements."[51] But, continuing with the hypothetical assumption that Mary Hitchcock "identified" the

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System. U.S. DEP'T OF HEALTH & HUMAN SERVS., OFFICE OF INSPECTOR GENERAL, A-01-13-00513, MEDICARE COMPLIANCE REVIEW OF MARY HITCHCOCK MEMORIAL HOSPITAL FOR 2009 THROUGH 2012 2 (2015), http://oig.hhs.gov/oas/reports/region1/11300513.pdf. It submitted slightly over 400,000 claims to Medicare Parts A and B during the period covered by the audit. *Id.*

45. *Id.* at 3. OIG randomly picked the 445 audited claims from a larger set of 86,143 claims that were "potentially at risk for billing errors." *Id.*

46. *Id.*

47. Merely retaining the money more than sixty days after "identifying" it would not be enough on its own to violate the FCA. Mary Hitchcock would still need to meet the additional requirement of "knowingly conceal[ing] or knowingly and improperly avoid[ing]" its obligation to return the overpayments. *See* 31 U.S.C. § 3729(a)(1)(G) (2012). This requirement is discussed *infra* in Part I.C.

48. This would only be true if the violations occurred after November 2, 2015. If the violations occurred on or before November 2, 2015, the maximum penalty would be $11,000. *See* 28 C.F.R. § 85.5 (2016); *infra* note 66.

49. Furthermore, OIG's audit only covered 445 claims out of 86,143 that were "potentially at risk for billing errors." MEDICARE COMPLIANCE REVIEW OF MARY HITCHCOCK MEMORIAL HOSPITAL, *supra* note 44, at 3. Assuming the overpayment rate of 57.3% (255/445) would hold constant across the entire set of 86,143 claims that OIG identified as "potentially at risk for billing errors," this would result in approximately 49,360 overpaid claims. Again assuming the maximum penalty of $21,563 per overpaid claim, Mary Hitchcock would be hit with $1.064 billion in penalties alone, not to mention an additional $450 million in treble damages (assuming the amount of overpayment on the total 49,360 claims would be proportional to the $770,735 in overpayments on the 255 confirmed overpaid claims). This ballooning liability is why the FCA keeps hospital compliance officers up at night.

50. *See supra* notes 16–18 and accompanying text.

51. MEDICARE COMPLIANCE REVIEW OF MARY HITCHCOCK MEMORIAL HOSPITAL, *supra* note 44, at 7.

overpayments more than 60 days before the audit, if a prosecutor looking for a political score or a *qui tam* plaintiff looking for a payday had gotten there before OIG, Mary Hitchcock might have faced an FCA action with the potential for devastating liability.

When a health care provider knows that particular claims were overpaid by particular amounts, there is no doubt the overpayments are "identified" within the meaning of the Sixty-Day Rule. But suppose instead that the provider is notified of a set of 1,000 claims that are at risk of having been overpaid, although no one knows with certainty which were actually overpaid, or by how much.[52] There are three moments at which any actually overpaid claims in this set can become "identified." First, the overpayments could be "identified" the moment the provider is put on notice that they *might* exist. Second, the overpayments could be deemed "identified" at the moment a reasonable investigation *should have* discovered and quantified the overpayments (even if, due to the provider's failure to conduct a competent investigation, the overpayments have not yet *in fact* been discovered and quantified). Finally, overpayments could be deemed "identified" only when the provider has actual knowledge of both (a) which claims were overpaid, and (b) the amount of the overpayments.

Under the first approach, the sixty-day clock would begin to run before the provider has even had a chance to begin its investigation. This may be an unfair result because, to determine which of the 1,000 flagged claims were actually overpaid, the provider would need to locate and review all relevant medical records, talk to the physicians who provided the services at issue, and then consult with coding experts (and possibly counsel) to determine whether the submitted codes were appropriate based on the supporting medical evidence.[53] Under the second approach, too, the sixty-day report and return clock may begin to run before a hospital on notice of potential overpayments knows what it actually needs to return. Only the third approach would not start the sixty-day clock until the provider knows for certain exactly how much it owes, and for which claims.

This Note argues for the third approach, namely that overpaid Medicare and Medicaid claims should not be deemed "identified" until a health care

52. This is roughly the same problem that the defendant hospitals faced in *Kane ex rel. United States v. Healthfirst, Inc*., 120 F. Supp. 3d 370 (S.D.N.Y. 2015). In *Healthfirst*, the defendant hospitals were given a list of more than 900 claims that were *potentially* overpaid, without knowing for sure that any particular claim had *in fact* been overpaid. *Id.* at 377. The *Healthfirst* case is discussed in depth *infra* in Part II.

53. This process is based on the *Healthfirst* defendants' explanation of the review process they would undertake if presented with a large set of potentially overpaid Medicaid claims. *See Healthfirst*, 120 F. Supp. 3d at 388–89.

provider has actual knowledge of their existence and amount. The Note is organized as follows: Part I introduces the relevant sources of law, including the FCA, the Sixty-Day Rule, and CMS's regulations implementing the Sixty-Day Rule for Medicare. Part II describes a recent district court decision grappling with the proper interpretation of "identified" in the context of Medicaid overpayments, a situation in which none of CMS's rules apply. Part III.A discusses how that case might be resolved if it dealt instead with claims under Medicare Part A or B, and thus were subject to CMS's most recent regulation defining "identified." Part III.B explains the problems with the existing regulatory scheme established by the FCA and current administrative interpretations of the Sixty-Day Rule. Part IV argues that providers should be required to have actual knowledge of overpayments for overpayments to be "identified."

I. STATUTORY AND REGULATORY FRAMEWORK: THE FALSE CLAIMS ACT & THE SIXTY-DAY RULE

A. The False Claims Act: Theory and History

The FCA is designed to punish and deter those who would defraud the federal government. Passed in 1863, the Act owes its existence to the Civil War, when sensational reports of fraud by military contractors jolted Congress into action to protect the public fisc.[54] The essential problem the FCA is designed to combat is an informational one: because of the federal government's size, the wide array of different programs it funds, and the fact that fraudsters generally act in secret, the government is unlikely to realize on its own when it has been duped.[55]

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54. *See, e.g.*, Universal Health Servs., Inc. v. United States *ex rel.* Escobar, 136 S. Ct. 1989, 1996 (2016); Krause, *supra* note 11, at 1369 (stating that Congress passed the FCA "in response to 'rampant fraud' perpetrated on the Union Army during the Civil War"); CLAIRE M. SYLVIA, THE FALSE CLAIMS ACT: FRAUD AGAINST THE GOVERNMENT § 2:2 (2d ed. 2010) ("During the Civil War, outraged by extensive fraud against the Government by army contractors, Congress enacted the False Claims Act."); *id.* § 2:6 (noting that the Civil War "produced extraordinary profits for dishonest government contractors"). Because of its Civil War roots, the Act is also known as the "Lincoln Law." *Id.* Examples of the outrageous fraud committed by military contractors during the Civil War include: repeatedly reselling the same mules to Army quartermasters, selling the Navy ships with rotted hulls disguised by new paint jobs, selling the Army boots made of cardboard that lasted through only a mile of marching, and providing soldiers with uniforms made from old rags that disintegrated when wet. James B. Helmer, Jr., *False Claims Act: Incentivizing Integrity for 150 Years for Rogues, Privateers, Parasites and Patriots*, 81 U. CIN. L. REV. 1261, 1264 (2013).

55. SYLVIA, *supra* note 54, §§ 1:2, 1:4 ("A critical barrier to the Government's efforts to control fraud is the lack of information about violations. Because fraud is secretive by nature, the Government cannot easily identify violations."). *See also id.* § 1:2 (noting that "the risk of being caught defrauding the Government historically has remained relatively low"). Medicare overpayment is a good example of

The FCA addresses this problem in two basic ways. First, it uses a *qui tam* mechanism.[56] This allows members of the general public, known as "relators," to bring actions on behalf of the government for violations of the Act and to share in the government's recovery.[57] When a relator brings a *qui tam* action under the FCA, the government may investigate the case and "intervene," meaning that it decides to handle the case instead of the relator.[58] If the government exercises its option to intervene, it has "the primary responsibility for prosecuting the action," and is not bound by any act of the relator.[59] Currently, relators are entitled to between 15 and 30% of the government's recovery.[60] The successful relator gets 15–25% of the recovery if the government intervenes,[61] and 25–30% if the government does not.[62] Thus, the first way the Act seeks to solve the government's information problem is by monetarily incentivizing private citizens who are aware of fraud against the government to bring it to the government's attention.[63]

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why the government cannot easily tell when it has been defrauded. All the government knows about the services provided in a given hospital transaction is what the provider chooses to tell it. This will be reflected in the code(s) that the provider submits to Medicare. If this code does not accurately describe the services rendered, the government will not know unless it reviews the underlying medical documentation (or learns of the true nature of the services in some other way). However, in practice, the government does not possess the capacity to review the supporting medical documentation of most Medicare claims before paying. In fact, as of 2010, the government conducted pre-payment review of supporting documentation for only about .002% of all Medicare claims. CTRS. FOR MEDICARE & MEDICAID SERVS., IMPLEMENTATION OF RECOVERY AUDITING AT THE CENTERS FOR MEDICARE & MEDICAID SERVICES 2 (2011), https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/recovery-audit-program/downloads/fy2010reportcongress.pdf.

56. *See* 31 U.S.C. § 3730 (2012). "*Qui tam*" is short for "*qui tam pro domino rege quam si ipso in hac parte sequitur*"—literally, "who sues on behalf of the king as well as for himself." Helmer, Jr., *supra* note 54, at 1262. As the term's use of the word "king" suggests, the United States inherited the *qui tam* concept from England. *Id.* Although there is a "long tradition of *qui tam* actions in England and the American colonies," Vt. Agency of Nat. Res. v. United States *ex rel.* Stevens, 529 U.S. 765, 774 (2000), *qui tam* provisions are fairly uncommon in the modern United States. In today's United States Code, only three statutes other than the FCA allow relators to sue on behalf of the federal government, and they "address narrow subject matters and are rarely invoked." SYLVIA, *supra* note 54, § 2:5.

57. *See* Helmer, Jr., *supra* note 54, at 1266.

58. SYLVIA, *supra* note 54, § 1:15.

59. 31 U.S.C. § 3730(c)(1).

60. 31 U.S.C. § 3730(d)(1)–(2); Helmer, Jr., *supra* note 54, at 1273.

61. 31 U.S.C. § 3730(d)(1).

62. 31 U.S.C. § 3730(d)(2).

63. *See* United States v. Northrop Corp., 59 F.3d 953, 963 (9th Cir. 1995) ("It is commonly recognized that the central purpose of the *qui tam* provisions of the FCA is to 'set up incentives to supplement government enforcement' of the Act." (quoting United States *ex rel.* Springfield Terminal Ry. Co. v. Quinn, 14 F.3d 645, 649 (D.C. Cir. 1994))). The False Claims Act's chief sponsor in the Senate, Senator Jacob Merritt Howard of Michigan, anticipated that the Act would convince participants in fraud to tell on one another. As he explained it, the general idea is "setting a rogue to catch a rogue." Cong. Globe, 37th Cong., 3d Sess. 955–56 (1863). One early district court opinion famously and colorfully analogized *qui tam* relators to privateers, explaining that fraud cases prosecuted with the help

Second, the FCA deters fraud by imposing punitive sanctions on violators.[64] Anyone who violates the Act is liable for treble damages plus civil monetary penalties.[65] As adjusted for inflation, these penalties currently range from a minimum of $10,781 to a maximum of $21,563 per false claim.[66] If the Act's only goal were to make the government whole again after it has been defrauded, punitive damages and monetary penalties would be unnecessary. However, the FCA seeks to do more than simply compensate the federal government for losses sustained due to fraud—it also seeks to deter would-be fraudsters from committing fraud in the first place.[67] The basic problem is that, when the likelihood of detection is low, fraudsters will realize the benefits of fraud more often than they will be sanctioned for it, and therefore fraud will generally be profitable.[68] One solution is to increase the odds of apprehension (this is the point of the *qui tam* provisions). Another is to increase the penalty via punitive damages so that, if you *are* caught, the consequences are more onerous.[69] Hopefully, at

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of *qui tam* relators "compare with the ordinary methods as the enterprising privateer does to the slow-going public vessel." United States v. Griswold, 24 F. 361, 366 (D. Or. 1885).

64. *See* United Health Servs., Inc. v. United States *ex rel.* Escobar, 136 S. Ct. 1989, 1996 (2016) (noting that liability under the FCA is "essentially punitive in nature").

65. 31 U.S.C. § 3729(a)(1).

66. The FCA provides that a person may be liable "for a civil penalty of not less than $5,000 and not more than $10,000, as adjusted by the Federal Civil Penalties Inflation Adjustment Act of 1990." *Id.* As adjusted for inflation, the current penalty per false claim ranges from a minimum of $10,781 to a maximum of $21,563. 28 C.F.R. § 85.5 (2016). The Department of Justice established the current penalties via an interim-final rule published on June 30, 2016. *See* Civil Monetary Penalties Inflation Adjustment, 81 Fed. Reg. 42,491 (June 30, 2016) (to be codified at 28 C.F.R. pts. 20, 22, 36, 68, 71, 76, and 85). The new penalty amounts apply "only to civil penalties assessed after August 1, 2016, whose associated violations occurred after November 2, 2015." *Id.* at 42,498. For FCA violations occurring on or before November 2, 2015, the minimum penalty is $5,500 and the maximum is $11,000. 28 C.F.R. § 85.3(a)(9). When an agency issues an interim-final rule, it does so without the typical notice-and-comment procedures beforehand. However, once the rule is already in place, the agency then solicits public comments and may amend the rule thereafter. *See* Michael Asimow, *Interim-Final Rules: Making Haste Slowly*, 51 ADMIN. L. REV. 703, 704 (1999).

67. *See* United States v. Bornstein, 423 U.S. 303, 309 (1976) (stating that the False Claims Act "was originally aimed principally at *stopping* the massive frauds perpetrated by large contractors during the Civil War") (emphasis added).

68. A. Mitchell Polinsky & Steven Shavell, *Punitive Damages: An Economic Analysis*, 111 HARV. L. REV. 869, 873–74 (1998) (explaining that, when the likelihood of detection for a particular wrong is low, "the level of liability imposed on [wrongdoers] when they *are* found liable needs to exceed compensatory damages so that, on average, they will pay for the harm that they cause"; otherwise, failure to impose punitive damages "would result in inadequate deterrence"); *see also* Robert D. Cooter, *Punitive Damages for Deterrence: When and How Much*, 40 ALA. L. REV. 1143, 1148 (1989) ("In the absence of punitive damages, enforcement errors enable injurers to externalize a portion of expected social costs that they cause."). For a numerical example of what makes fraud too profitable when the apprehension rate is less than 100%, see *infra* note 70.

69. *See* SYLVIA, *supra* note 54, § 1:3 ("To the extent that individuals engage in fraud against the Government because it is profitable, the economic theory of law enforcement suggests that fraud can be reduced by making it more costly—in other words, by increasing the sanctions for the behavior. If

a certain point, the sanctions for being caught will be severe enough to dissuade rational people from engaging in fraud, even though detection remains unlikely.[70] Thus, by imposing punitive damages and significant monetary penalties, the FCA aims to deter fraud by making it unprofitable, even if the government struggles to detect fraud once it has been committed.[71]

Although the Act was originally addressed to the problem of fraud in military contracting, the government soon found it to be useful in fighting

individuals who violate the law are required to pay more than the actual harm they impose, the sanctions should have a deterrent effect, even if the risk of getting caught is low."); *see also* RESTATEMENT (SECOND) OF TORTS § 908 (AM. LAW INST. 1979) ("Punitive Damages are . . . awarded against a person to punish him for his outrageous conduct *and to deter him and others like him from similar conduct in the future*.") (emphasis added); RICHARD A. POSNER, ECONOMIC ANALYSIS OF LAW 217 (6th ed. 2003) (noting that "[p]unitive damages can be adjusted upward to take account of the difficulty of detection"); Exxon Shipping Co. v. Baker, 554 U.S. 471, 492, 494 (2008) ("[T]he consensus today is that punitives are aimed not at compensation but principally at retribution and *deterring harmful conduct*. . . . [H]eavier punitive damage awards have been thought to be justifiable when wrongdoing is hard to detect (increasing chances of getting away with it) . . . .") (emphasis added).

70. A simple example demonstrates the point: suppose that the risk of being caught for committing fraud is only 25%. If fraud is only punished with compensatory damages, then a rational person contemplating fraud might choose to defraud the government of $1,000, because there is no cost to him (even if he is caught, all he will have to do is return the $1,000), while the benefit is $750 (*i.e.*, the benefit of getting away with it—$1,000 of profit—times the odds of getting away with it, 75%). If, however, the government imposes punitive quintuple damages for a fraud conviction, then the rational potential fraudster would refrain, because now the cost of committing fraud is $1,000 ($4,000—equal to $5,000 in damages minus the $1,000 gained from fraud—multiplied by the 25% likelihood of being caught), while the benefit is still only $750. The general rule advanced by Law and Economics scholars is that the level of punitive damages necessary to achieve adequate deterrence is the reciprocal of the likelihood of apprehension, so that a 1/4 chance of being caught requires a punitive to compensatory damages ratio of at least 4:1 to adequately deter the undesirable action. *See* United States v. Rogan, 517 F.3d 449, 454 (7th Cir. 2008) (Easterbrook, C.J.) ("The lower the rate of a fraud's detection, the higher the multiplier required to ensure that crime does not pay.") (citation omitted); Polinsky & Shavell, *supra* note 68, at 887 ("[I]f a defendant can sometimes escape liability for the harm for which he is responsible, the proper magnitude of damages is the harm the defendant has caused, multiplied by a factor reflecting the probability of his escaping liability."); Cooter, *supra* note 68, at 1148 ("In general, the punitive multiple should equal the reciprocal of the enforcement error for the sake of deterrence, which I call the 'rule of the reciprocal.'"). Of course, there is an outer limit to this principle: if there is a 10% chance of being caught (or less), punitive damages of ten times the harm caused (or more) may violate federal due process. *See* State Farm Mut. Auto. Ins. Co. v. Campbell, 538 U.S. 408, 425 (2003) (stating that "few awards exceeding a single-digit ratio between punitive and compensatory damages . . . will satisfy due process").

71. A further observation about the relationship between deterrence and detection: Because the FCA allows *qui tam* actions, any increase in the amount of damages available for violations of the Act will create correspondingly greater incentives for relators to file suit. *See* Margaret H. Lemos, *Special Incentives to Sue*, 95 MINN. L. REV. 782, 793 (2011) (noting that damage enhancements "encourage more private litigation by offering plaintiffs and their attorneys a larger recovery"). Thus, as damages increase, the likelihood that fraud will be exposed goes up in tandem. Policymakers need to keep this relationship in mind, or else they risk imposing liability that is more severe than necessary to achieve adequate deterrence.

other kinds of fraud against the government as well.[72] In 1943, however, revisions to the Act seriously undermined its efficacy.[73] The impetus for these amendments was the perception that the *qui tam* system was being abused. Of particular concern were so-called "parasitic" *qui tam* suits, where potential relators would "lurk in federal courthouses for criminal indictments to be brought against defense contractors [and] then immediately file a civil False Claims Act case based on the indictment against the same contractor."[74] These "parasitic" relators were not helping to solve the government's information problem. Rather, they merely sought to turn an opportunistic profit from what little information the government *did* manage to collect. The 1943 amendments not only reduced the *qui tam* relator's share of the recovery (thus decreasing the public's financial incentive to notify the government of fraud),[75] but also established a significant hurdle for relators to even make it past dismissal—if *anyone* in the government had *any* knowledge of the alleged fraud when the relator filed her action, the *qui tam* action would be dismissed.[76]

Because of the 1943 amendments, the FCA fell into disuse during the mid-twentieth century.[77] By the 1980s, however, fraud against the government was again on the rise, this time because of President Reagan's massive Cold War military spending.[78] This spike in fraud led Congress to pass the 1986 amendments, reinvigorating the dormant FCA.[79] The 1986 amendments accomplished this by, among other things, increasing the

72. *See* SYLVIA, *supra* note 54, § 2:6 ("Nothing in the [FCA] limited its reach to war supplies, and over time, the law was applied in other areas where large sums of federal money were dispensed."). For instance, in *Pooler v. United States*, 127 F. 519, 519 (1st Cir. 1904), the government invoked the False Claims Act to recover wrongfully received pension funds.

73. *See* Helmer, Jr., *supra* note 54, at 1270 (stating that the 1943 amendments "destroyed *qui tam* as an effective fraud-fighting tool").

74. *Id.* at 1267.

75. Under the original 1863 Act, relators were entitled to 50% of any recovery; the 1943 Amendments decreased this figure to a maximum of 10% if the government intervened and prosecuted the case instead of the relator, and a maximum of 25% if the government elected not to intervene and allowed the relator to proceed on her own. *Id.* at 1266, 1271.

76. *Id.* at 1270.

77. In 1986, on the eve of the next round of FCA amendments, there was only one live *qui tam* case in the entire United States. *Id.* at 1272–73. *See also* SYLVIA, *supra* note 54, § 2:9 ("By the 1980s, it was evident that the False Claims Act was no longer an effective tool against fraud.").

78. *See* Helmer, Jr., *supra* note 54, at 1271 ("In the 1980's, President Reagan committed to a plan of enormous national defense spending. . . . The vast sums being spent by the Department of Defense presented opportunities to cheat the Government, which proved irresistible to many."); SYLVIA, *supra* note 54, § 2:9 ("By the 1980s the magnitude of fraud against the Government had grown to previously unimaginable proportions.").

79. *See* SYLVIA, *supra* note 54, § 2:2 ("In 1986, Congress amended the Act again to revitalize it and make it a more effective law enforcement tool.").

financial incentives for *qui tam* relators to bring suit,[80] increasing the magnitude of the penalties that could be recovered for each false claim, allowing victorious relators to recover attorney fees, and protecting relators from retaliation by their employers.[81] The amendments also modified the stringent "any government knowledge" bar that had previously been such an imposing obstacle to *qui tam* suits, replacing it with a "public disclosure" exception that proved friendlier to relators.[82] The public disclosure exception prevents a *qui tam* relator from bringing any action based on allegations previously disclosed (1) in a federal criminal, civil, or administrative hearing where the federal government is a party, (2) in a federal report, hearing, audit, or investigation, or (3) by the news media.[83] This exception has been "the most litigated provision of the 1986 False Claims Act."[84]

Importantly for purposes of this Note, the 1986 amendments also added the so-called "reverse" false claim to the government's arsenal.[85] Before these amendments, only "direct" false claims had been expressly authorized.[86] A direct false claim is an attempt to fraudulently *obtain payment from* the government.[87] This is the basic scenario where a contractor submits a bill to the government for goods he knows to be substandard, so as to fraudulently receive full payment from the

80. Under the 1986 Amendments (which remain in force today), a *qui tam* relator can recover 15–25% of the total award if the United States prosecutes the case and 25–30% if the relator prosecutes it on her own. *See supra* notes 60–62 and accompanying text. This was up from a maximum of 10% (if the government prosecuted) and 25% (if the relator prosecuted) under the 1943 Amendments. Helmer, Jr., *supra* note 54, at 1271.

81. Helmer, Jr., *supra* note 54, at 1273–74.

82. *Id.* at 1274.

83. 31 U.S.C. § 3730(e)(4) (2012).

84. Helmer, Jr., *supra* note 54, at 1274.

85. Under the 1986 amendments, the "reverse" false claims provision was located at 31 U.S.C. § 3729(a)(7). It is now codified at § 3729(a)(1)(G). Today, a person is liable under the reverse false claims provision when she

> knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government.

31 U.S.C. § 3729(a)(1)(G) (2012). In its original 1986 form, the reverse false claims provision did not include the final clause, which was added in 2009 by the Fraud Enforcement and Recovery Act. *See infra* note 93 and accompanying text.

86. Pre-1986, there was some disagreement among the courts as to whether the old statutory language permitted reverse false claims. *See* S. REP. NO. 99-345, at 15 (1986), *reprinted in* 1986 U.S.C.C.A.N. 5266, 5280 (stating that the Justice Department "testified that recent court rulings had produced an ambiguity as to whether such 'reverse false claims' were covered by the [pre-1986] False Claims Act").

87. As formulated today, a direct false claim occurs when a person "knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval." 31 U.S.C. § 3729(a)(1)(A).

government.[88] In contrast, a reverse false claim is an attempt to fraudulently *avoid payment to* the government.[89] Thus, the reverse fraudster already owes the government money, and fraudulently attempts to avoid paying some or all of it. An example may be helpful. Suppose that an oil company produces oil from government-owned lands, and therefore owes the government royalties. The amount of these royalties depends on how much oil the company produces from these public lands, as well as the price for which the oil sells. If the company purposely understates the price for which it is selling the oil to decrease the amount of royalties it owes the government, this is a reverse false claim.[90]

Congress was not done after 1986. In 2009, the specter of fraud against the government again reappeared, and again Congress responded with new amendments to the FCA. This time, the identified threat was that subcontractors might defraud the government out of economic stimulus money dispensed in the wake of the 2008 financial crisis.[91] In response, Congress passed the Fraud Enforcement and Recovery Act of 2009 (FERA).[92] FERA made two important changes to the FCA with implications

88. The direct false claim is the scenario the False Claims Act was originally designed to address—the situation where, for example, a military contractor promises to provide good quality uniforms to the Army, but knows that he will in fact provide uniforms of such poor quality that they will dissolve when it rains, and then obtains full payment for those substandard goods from the government anyway. *See* Helmer, Jr., *supra* note 54, at 1264 (listing sale of defective uniforms that disintegrated when wet as one of the examples of Civil War fraud that galvanized Congress to pass the False Claims Act).

89. *See* SYLVIA, *supra* note 54, § 4:1 ("Congress added this so-called 'reverse false claim' provision in 1986 to clarify that fraudulent efforts to reduce payments *to* the Government were substantively indistinguishable from fraudulent efforts to obtain payments *from* the Government."); S. REP. NO. 111-10, at 13–14 (2009), *reprinted in* 2009 U.S.C.C.A.N. 430, 441 (explaining that a "reverse false claim" is so called "because it is designed to cover Government money or property that is knowingly retained by a person even though they have no right to it").

90. This example is based on *United States ex rel. Johnson v. Shell Oil Co*., 33 F. Supp. 2d 528, 532 (E.D. Tex. 1999).

91. *See* S. REP. NO. 111-10, at 4 (2009), *reprinted in* 2009 U.S.C.C.A.N. 430, 433 ("The effectiveness of the False Claims Act has recently been undermined by court decisions which limit the scope of the law and, in some cases, allow subcontractors paid with Government money to escape responsibility for proven frauds. The False Claims Act must be corrected and clarified in order to protect from fraud the Federal assistance and relief funds expended in response to our current economic crisis."). The main purpose of the 2009 amendments was to overrule the Supreme Court's decision in *Allison Engine Co. v. United States ex rel. Sanders*, 553 U.S. 662 (2008). *See* S. REP. NO. 111-10, at 10 (2009), *as reprinted in* 2009 U.S.C.C.A.N. 430, 438 ("This section amends the FCA to clarify and correct erroneous interpretations of the law that were decided in *Allison Engine* . . . ."). In *Allison Engine*, the Court had held that when a subcontractor submits a fraudulent claim for payment to a contractor, it does not violate the FCA unless it intended for *the government* to pay the claim, as opposed to just *the contractor*. *See Allison Engine*, 553 U.S. at 671–72; S. REP. NO. 111-10, at 10 (2009), *reprinted in* 2009 U.S.C.C.A.N. 430, 438. The chief aim of the 2009 amendments was to close this loophole for subcontractors "who knowingly submit false claims to general contractors and are paid with Government funds." S. REP. NO. 111-10, at 10–11 (2009), *reprinted in* 2009 U.S.C.C.A.N. 430, 438.

92. Pub. L. 111-21, 123 Stat. 1617 (2009).

for Medicare and Medicaid overpayments. First, FERA added a final clause to the reverse false claims provision, extending liability to anyone who "knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government."[93] Second, FERA defined the key term "obligation" to include "the retention of any overpayment."[94] FERA thus made clear that a health care provider can violate the FCA by retaining a Medicare or Medicaid overpayment.[95]

Since 1986, the government has significantly increased its use of the FCA. While total FCA recoveries in 1987 totaled just $86.4 million,[96] by 1994 recoveries under the Act eclipsed $1 billion.[97] Since 2000, total recoveries have fallen under $1 billion just once, and reached a record high of more than $5.7 billion in 2014.[98] A record 754 *qui tam* actions were filed under the FCA in 2013,[99] a far cry from the single *qui tam* suit that was pending when Congress took up the 1986 amendments.[100]

Today, health care fraud is the single largest source of government recoveries under the FCA. Of the total $3,583,816,068 recovered by the government through FCA settlements and judgments in fiscal year 2015, more than half (just under $2 billion) came from health care cases.[101] By contrast, FCA recoveries related to defense spending were just under $260 million in that same year.[102] Despite the FCA's origins in defense fraud, health care fraud has now become the primary area of enforcement.[103]

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93. 31 U.S.C. § 3729(a)(1)(G) (2012). *See also* S. REP. NO. 111-10, at 13–14 (2009), *reprinted in* 2009 U.S.C.C.A.N. 430, 441–442 (discussing this addition to § 3729(a)(1)(G)).

94. 31 U.S.C. § 3729(b)(3) (defining "obligation" as an "established duty, whether or not fixed, arising from an express or implied contractual, grantor-grantee, or licensor-licensee relationship, from a fee-based or similar relationship, from statute or regulation, *or from the retention of any overpayment*") (emphasis added).

95. *See* James J. Belanger & Scott M. Bennett, *The Continued Expansion of the False Claims Act*, 4 J. HEALTH & LIFE SCI. L. 26, 33 ("FERA amended the FCA so it would apply to the retention of an overpayment by the government."). As explained further *infra* in Part I.C, to violate the FCA the provider would still need to "knowingly conceal" or "knowingly and improperly avoid" its obligation to return the overpayment. *See* 31 U.S.C. § 3729(a)(1)(G).

96. *Fraud Statistics—Overview: Oct. 1, 1987–Sept. 30, 2015*, U.S. DEP'T OF JUSTICE, CIVIL DIV. (Nov. 23, 2015), https://www.justice.gov/opa/file/796866/download [hereinafter DOJ, Fraud Statistics—Overview].

97. *Id.*

98. *Id.*

99. *Id.*

100. *See* Helmer, Jr., *supra* note 54, at 1272–73 (noting that just one *qui tam* case was pending in the United States when Congress held hearings to discuss amendments to the FCA in 1986).

101. DOJ, Fraud Statistics—Overview, *supra* note 96; DOJ, Fraud Statistics—Health and Human Services, *supra* note 7.

102. *Fraud Statistics—Dep't of Defense: Oct. 1, 1987–Sept. 30, 2015*, U.S. DEP'T OF JUSTICE, CIVIL DIV. (Nov. 23, 2015), https://www.justice.gov/opa/file/796866/download.

103. *See* Helmer, Jr., *supra* note 54, at 1281 ("[M]assive fraud against the Medicare system has overshadowed defense cases brought pursuant to the False Claims Act."); SYLVIA, *supra* note 54, § 2:15

B. The ACA's Sixty-Day Rule and CMS's Implementing Regulations

The final piece of legislation in the Medicare and Medicaid overpayment jigsaw puzzle comes from the ACA. As part of the ACA, Congress passed the so-called "Sixty-Day Rule," under which a provider who receives an overpayment must report and return it within "60 days after the date on which the overpayment was *identified*."[104] Otherwise, the overpayment constitutes an "obligation" for purposes of the FCA.[105]

Significantly, however, Congress did not define the key term "identified."[106] This omission creates a problem when health care providers are notified that a particular set of Medicare or Medicaid claims *potentially* contains *some* overpayments: at what point are those overpayments "identified"? Once they are "identified," the sixty-day clock starts to run, and each overpayment that is not returned by day sixty-one may cost the provider triple the amount of the overpayment plus up to $21,563 for a violation of the FCA. Plus, the provider may be cut off from further participation in the relevant program.[107] The proper interpretation of the term "identified" is thus of no small importance to the provider community.[108]

CMS has taken a piecemeal approach to clarifying when an overpayment is "identified." In 2014, CMS issued a final rule defining "identified" only

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(noting that, since 1986, "the health care industry has gradually become the largest source of cases under the Act"); Krause, *supra* note 4, at 128–29 (describing the FCA as a "basic military fraud statute" that has since developed "into a multi-million dollar weapon against health care fraud").

104. 42 U.S.C. § 1320a-7k(d)(2) (2012) (emphasis added). The obligation of a provider to report and return overpayments is established in § 1320a-7k(d)(1). Then, § 1320a-7k(d)(2) provides the time limit within which an overpayment must be reported and returned: "An overpayment must be reported and returned under paragraph (1) by the later of—(A) the date which is 60 days after the date on which the overpayment was identified; or (B) the date any corresponding cost report is due, if applicable."

105. 42 U.S.C. § 1320a-7k(d)(3). Specifically, this provision states: "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."

106. *See* Kane *ex rel.* United States v. Healthfirst, Inc., 120 F. Supp. 3d 370, 381 (S.D.N.Y. 2015) ("Congress did *not* define the pivotal word 'identified,' which triggers the sixty-day report and return clock, in the text of the ACA."); Belanger & Bennett, *supra* note 95, at 34 ("One large gap in [the ACA] is its failure to explain when an overpayment is *identified*. The term could incorporate an entire spectrum of mental states, ranging from actual knowledge of the overpayment, to simply having information that reasonably suggests there has been an overpayment. Because of the lack of specificity in [the ACA], how this provision will play out in the field remains to be seen.").

107. *See supra* note 16 and accompanying text.

108. *See, e.g.*, Tyler Robinson & Roger R. Clayton, *Rise of the "Reverse" False Claim & Proposed Rules from CMS on Reporting & Returning Overpayments*, 23 IDC QUARTERLY, no. 4, Jan. 2014 (recommending that, in the absence of an authoritative definition of "identified," "providers should *immediately* institute policies and procedures to field any potential complaints with respect to potential Medicare overpayments"), http://www.iadtc.org/news/news.asp?id=152147.

for purposes of Medicare Parts C and D (the "C and D Rule").[109] Under the C and D Rule, an entity has "identified" an overpayment from Medicare Part C or D when it "has determined, or should have determined through the exercise of reasonable diligence, that [it] has received an overpayment."[110]

CMS has also issued a separate final rule covering overpayments from Medicare Parts A and B (the "A and B Rule"). CMS first gave notice of its proposed A and B Rule in 2012, two years before it finalized the C and D Rule.[111] Under the proposed A and B Rule, an overpayment would have been "identified" when a person (1) has "actual knowledge" of the overpayment, (2) acts in "reckless disregard" of the overpayment, or (3) acts in "deliberate ignorance" of the overpayment.[112] As a policy justification for this interpretation, CMS explained that this interpretation would adequately incentivize health care providers to diligently report and return overpayments, whereas requiring actual knowledge of the overpayment might allow hospitals to avoid any obligation to repay by simply maintaining purposeful ignorance.[113]

The proposed A and B Rule alarmed the provider community. The following comment by Asante Health System in Oregon was typical of provider sentiment:

> The proposed rule ignores what a credible and methodical process involves to determine if an overpayment was received. . . . [It] overlooks the fact-finding work a hospital must do, and the effort required to establish the scope of a problem, assess what happened and why, and determine the actual amount that is due.[114]

Providers worried that CMS's definition would mean they had "identified" overpayments when they were merely put on notice of a large set of potentially overpaid claims, and thus would only have sixty days to

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109. 42 C.F.R. § 422.326(c) (2016) (Part C); 42 C.F.R. § 423.360(c) (2016) (Part D).

110. 42 C.F.R. § 422.326(c). *See also* 42 C.F.R. § 423.360(c) (same).

111. *See* Reporting and Returning of Overpayments, 77 Fed. Reg. 9179, 9180 (proposed Feb. 16, 2012) (to be codified at 42 C.F.R. pts. 401 and 405).

112. *Id.* In reaching this conclusion about the correct interpretation of "identified," CMS reasoned that Congress's reference to the term "knowing" in 42 U.S.C. § 1320a-7k(d)(4)(A) indicated Congress's intent that the "knowing" standard should apply to define the term "identified," which is located in a neighboring provision, 42 U.S.C. § 1320a-7k(d)(2)(A). *See id.* at 9182. Section 1320a-7k(d)(4)(A) defines "knowing" by reference to that same term's definition in the FCA. In the FCA, "knowing" is defined to include when a person has "actual knowledge" of information, or acts in "deliberate ignorance" or "reckless disregard" of the truth or falsity of information. 31 U.S.C. § 3729(b)(1)(A) (2012).

113. Reporting and Returning of Overpayments, 77 Fed. Reg. at 9182.

114. Public Comment to CMS Proposed Rule, Asante Health System, at 4, http://www.regulations.gov/#!documentDetail;D=CMS-2012-0020-0089.

complete an investigation into the overpayments, even if doing so were impracticable.[115] Because not all overpayments are equally easy to sort out,[116] providers argued that sixty days would not be sufficient to complete an investigation in all cases.[117] Accordingly, many argued that overpayments should only be deemed "identified" once the provider has actual knowledge of them.[118] Three years after issuing the proposed A and B Rule, CMS announced on February 17, 2015 that it would require an additional year before publishing the final A and B Rule due to "the complexity of the rule and scope of comments."[119]

After sifting through "approximately 200 timely pieces of correspondence," CMS published the final A and B Rule on February 12,

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115. For instance, Emory Healthcare in Atlanta complained that "[t]he proposed rule fails to recognize the wide variance in the nature and amount of potential overpayments to providers. Conducting a credible investigation to determine if an overpayment was received, and if so, the correct amount of the overpayment can, and often does, take much longer than 60 days." Public Comment to CMS Proposed Rule, Emory Healthcare, at 2, https://www.regulations.gov/document?D=CMS-2012-0020-0152. The American Medical Association noted that "[p]hysicians who identify an initial overpayment are likely to inquire over the following days or weeks regarding the existence of other overpayments based on the same error. This will be a particularly laborious process for physicians who utilize external billing services and need to obtain records from third-parties." Public Comment to CMS Proposed Rule, Am. Med. Ass'n, at 2, https://www.regulations.gov/document?D=CMS-2012-0020-0099. And the California Hospital Association added that

> [i]n certain situations, billing investigations could require the analysis of hundreds, or possibly thousands, of claims, often with some manual component to review and evaluate. Quantifying the overpayment within 60 days could be impossible if it stems from underlying decisions about medical necessity that can only be determined by review of the medical records.

Public Comment to CMS Proposed Rule, Cal. Hosp. Ass'n, at 3, http://www.regulations.gov/#!documentDetail;D=CMS-2012-0020-0085.

116. *See* Public Comment to CMS Proposed Rule, Husch Blackwell for Four State Health Care Provider Ass'ns, at 2, ("Overpayments come in different shapes and sizes. They may arise from data entry errors, lapses in documentation, faulty assumptions, incomplete information, incorrect agency guidance, and any number of other sources. They may be isolated or systemic. The dollars involved may be large or small."), https://www.regulations.gov/document?D=CMS-2012-0020-0181.

117. Public Comment to CMS Proposed Rule, Cal. Hosp. Ass'n, *supra* note 115, at 3 ("Even assuming the provider has resolved to its satisfaction questions regarding the applicable underlying payment rules (which often are unclear or subject to differing interpretations), simply completing the analysis of the claims or medical records at issue may take longer than 60 days.").

118. *E.g.*, Public Comment to CMS Proposed Rule, Ariz. Hosp. and Healthcare Ass'n, at 1–2, https://www.regulations.gov/document?D=CMS-2012-0020-0195; Public Comment to CMS Proposed Rule, Fed'n of Am. Hosps., at 6, http://www.regulations.gov/#!documentDetail;D=CMS-2012-0020-0204.

119. Medicare Program; Reporting and Returning of Overpayments; Extension of Timeline for Publication of the Final Rule, 80 Fed. Reg. 8247 (Feb. 17, 2015) (to be codified at 42 C.F.R. pts. 401 and 405). The Social Security Act requires CMS to provide notice if it requires more than three years from the date on which it issued a proposed rule to publish the final rule. *Id.* at 8247. In explaining its decision to take another year to consider the final rule, CMS stated that "[b]ased on both public comments received and internal stakeholder feedback, we have determined that there are significant policy and operational issues that need to be resolved in order to address all of the issues raised by comments to the proposed rule." *Id.* at 8248.

2016.[120] The final rule differs from the proposed rule, providing that

> [a] person has identified an overpayment when the person has, or should have through the exercise of reasonable diligence, determined that the person has received an overpayment and quantified the amount of the overpayment. A person should have determined that the person received an overpayment and quantified the amount of the overpayment if the person fails to exercise reasonable diligence and the person in fact received an overpayment.[121]

The final A and B Rule further explained that a provider has exercised "reasonable diligence" when, "in response to obtaining credible information of a potential overpayment," the provider assigns "qualified individuals" to conduct an investigation "in good faith and in a timely manner."[122] Unlike the C and D Rule, the A and B Rule at least requires that a reasonably diligent provider would have been able to *quantify* any overpayments before they are "identified," not just determine that they exist. However, neither the A and B Rule nor the C and D Rule predicates "identification" on the provider's actual knowledge of the overpayments. Instead, it is enough that a "reasonably diligent" provider *would have* been able to determine that it received overpayments (under the C and D Rule), or that such a provider *would have* been able to both determine that the overpayments exist and quantify them (under the A and B Rule), even if the provider in question has not actually done so.

Neither the A and B Rule nor the C and D Rule applies to Medicaid overpayments. As of the writing of this Note, CMS has not published a rule defining "identified" for purposes of Medicaid.[123] In Part II, I discuss the first court decision to interpret "identified" in the context of Medicaid overpayments, and thus without controlling regulatory guidance from CMS.

C. Structure of a Reverse False Claim in the Medicare/Medicaid Overpayment Context

The above material described the FCA and the Sixty-Day Rule in isolation from one another. But how do they interact to turn an overpayment

120. *See* Reporting and Returning of Overpayments, 81 Fed. Reg. 7654, 7655 (Feb. 12, 2016) (to be codified at 42 C.F.R. pts. 401 and 405).

121. 42 C.F.R. § 401.305(a)(2) (2016).

122. Reporting and Returning of Overpayments, 81 Fed. Reg. at 7661. Another component of "reasonable diligence" is "proactive compliance activities conducted in good faith by qualified individuals to monitor for the receipt of overpayments." *Id.*

123. *See id.* at 7655 ("No final rule has been published that addresses Medicaid requirements.").

of Medicare or Medicaid funds into FCA liability? The foundation of a reverse false claim is what is known as an "obligation." The FCA provides that a defendant is liable for a reverse false claim only when it "knowingly conceals or knowingly and improperly avoids or decreases *an obligation* to pay or transmit money or property to the Government."[124] Without an obligation there can be no liability. How is an obligation acquired? In the Sixty-Day Rule, Congress established particular circumstances under which the mere retention of improper Medicare or Medicaid payments creates an obligation. Specifically, the Sixty-Day Rule provides that failure to report and return a Medicare or Medicaid overpayment within sixty days from the date on which the overpayment is "identified" produces an obligation.[125]

Once a defendant acquires an obligation, the FCA does not impose liability unless the defendant "knowingly conceals" or "knowingly and improperly avoids or decreases" the obligation.[126] To act "knowingly" with regard to a particular piece of information, a defendant must act (i) with "actual knowledge" of the information, (ii) in "deliberate ignorance" of the information's truth or falsity, or (iii) in "reckless disregard" of the information's truth or falsity.[127] The defendant need not have any "specific intent to defraud."[128] Because the FCA itself prescribes this step of the analysis, it is the same regardless of whether the A and B Rule, C and D Rule, or no rule applies. In other words, CMS's rules affect *when a provider acquires an obligation*, but not *how that obligation turns into FCA liability*.

II. THE *HEALTHFIRST* DECISION

In *Kane ex rel. United States v. Healthfirst, Inc.*,[129] the United States District Court for the Southern District of New York considered whether several hospitals had "identified" potential Medicaid overpayments for purposes of the Sixty-Day Rule and the FCA. *Healthfirst* is noteworthy as the first case to interpret the term "identified."[130] Because *Healthfirst* was a Medicaid case, its outcome was not (and would not now be) controlled by either the A and B or C and D Rule.[131]

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124. 31 U.S.C. § 3729(a)(1)(G) (2012) (emphasis added).
125. 42 U.S.C. § 1320a-7k(d)(2) (2012).
126. 31 U.S.C. § 3729(a)(1)(G).
127. 31 U.S.C. § 3729(b)(1)(A).
128. 31 U.S.C. § 3729(b)(1)(B).
129. 120 F. Supp. 3d 370 (S.D.N.Y. 2015).
130. *See id.* at 384 ("Congress did not define the term 'identified' in the ACA, and no other court has weighed in on its meaning or on the application of the ACA sixty-day rule. This case thus presents a novel question of statutory interpretation.").
131. *See supra* note 123 and accompanying text.

A. The Facts[132]

The *Healthfirst* defendants were several New York City hospitals[133] ("the Hospitals"), which, due to a software glitch, received Medicaid overpayments from the New York State Department of Health.[134] The Hospitals had a contractual agreement with Healthfirst (a private, non-profit insurance program), whereby the Hospitals provided care to Medicaid patients covered by Healthfirst's insurance, and Healthfirst then compensated the Hospitals for their services.[135] Healthfirst, in turn, received a monthly reimbursement fee from the New York State Department of Health for its Medicaid-covered patients.[136]

When Healthfirst paid the Hospitals, it also sent them an electronic code indicating whether the Hospitals could pursue further payment from a secondary payor (like Medicare or Medicaid).[137] The Hospitals' problems began when a glitch in Healthfirst's billing software caused Healthfirst to send codes to the Hospitals that incorrectly told the Hospitals they could seek additional payment from Medicaid.[138] Consequently, the Hospitals improperly submitted Medicaid claims to the New York State Department of Health, resulting in the Hospitals' receiving Medicaid payments to which they were not entitled.[139]

The Hospitals began receiving overpayments in January 2009, but did

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132. Because *Healthfirst* arose on a motion to dismiss, the court accepted as true the factual background alleged in the United States' and New York's complaints for purposes of ruling on the motion. *See Healthfirst*, 120 F. Supp. 3d at 375 n.2 (noting that the facts of the case came from the complaints filed by the United States and New York, and that the two complaints contained facts that were "virtually, if not completely, identical").

133. The hospitals involved in the case were Beth Israel Medical Center d/b/a Mount Sinai Beth Israel, St. Luke's-Roosevelt Hospital Center d/b/a Mount Sinai St. Luke's and Mount Sinai Roosevelt, and Long Island College Hospital. *Id.* at 375. The three hospitals all belonged to Continuum Health Partners, a network of non-profit hospitals. *Id.* at 375–76. In July 2013, Continuum Health Partners combined with Mount Sinai Medical Center to form the Mount Sinai Health System. *See* Anemona Hartocollis, *2 Hospital Networks Agree to Merge, Raising Specter of Costlier Care*, N.Y. TIMES (Jul. 16, 2013), http://www.nytimes.com/2013/07/17/nyregion/2-hospital-networks-agree-to-merge-raising-specter-of-costlier-care.html?_r=0. *See also Healthfirst*, 120 F. Supp. 3d at 376 n.5 (discussing the merger). In the interest of full disclosure, my mother is an attorney for Mount Sinai, although she was not involved with the *Healthfirst* litigation and she did not share any non-public information about the case with me. This disclosure is repeated at the end of the Note in my author acknowledgments.

134. *Healthfirst*, 120 F. Supp. 3d at 376–77.

135. *Id.* at 376.

136. *Id.* Recall that Medicaid expenses are shared between the states and the federal government. States pay providers first, and then are partially reimbursed by the federal government. *See supra* notes 2 and 23.

137. *Healthfirst*, 120 F. Supp. 3d at 376.

138. *Id.*

139. *Id.* at 376–77.

not suspect anything was amiss until September 2010 when auditors with the New York State Comptroller's office noticed the potential problem and brought it to the Hospitals' attention.[140] Upon investigation, the parties discovered the software malfunction that had caused the overpayments.[141] The Hospitals then assigned an employee, Robert Kane, to determine which claims had been improperly submitted.[142] On February 4, 2011, Kane emailed a spreadsheet to the Hospitals containing more than 900 claims that had the problematic billing code and therefore *might* have been overpaid.[143] According to the Hospitals, at this point a rigorous and time-consuming review was necessary to determine what claims had *actually* been overpaid. The Hospitals described this review process as follows:

> Faced with an internal audit that suggests that some percentage of sampled claims for certain procedures have been improperly coded, a provider would likely review the findings by retrieving and reviewing the medical records involved, discussing the cases with the physicians who furnished the services, and consulting with staff with expertise in coding and, possibly, counsel. If the review confirms the audit determination, there may be a need to extend the audit to review claims outside of the audit sample or to do more sampling from different time periods or different physicians. . . . Assuming that the audit identified overpayments, the provider's reimbursement staff will then have to make arrangements to return the overpayments. Doing so may require the identification of every specific claim that has been overpaid by claim number, additional governmental identifiers, date of service, patient, and amount billed and paid.[144]

Four days after receiving the spreadsheet, the Hospitals fired Kane.[145] While the Hospitals promptly repaid five of the improper claims, they did not reimburse the government for more than 300 of the claims until June of 2012, after the government had issued a Civil Investigative Demand.[146]

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140. *Id.* at 377.

141. *Id.* The glitch was fixed on December 13, 2010. *Id.*

142. *Id.*

143. *Id.*

144. *Id.* at 388–89 (quoting Defendant's Memorandum of Law in Support of Its Motion to Dismiss the Government's Complaint, at 10–11). For other hospitals' corroborations of the difficulty of conducting an investigation into potential overpayments, see *supra* note 115.

145. *Healthfirst*, 120 F. Supp. 3d at 377.

146. *Id.* at 377–78. The Civil Investigative Demand is a tool by which the government can force entities under investigation for FCA violations to produce relevant information and testimony. *See* CHARLES DOYLE, CONG. RESEARCH SERV., R40785, QUI TAM: THE FALSE CLAIMS ACT AND RELATED FEDERAL STATUTES 19 (2009).

Ultimately, it turned out that roughly half the claims in Kane's spreadsheet had in fact been overpaid.[147]

On April 5, 2011, Kane filed a *qui tam* action against the Hospitals and Healthfirst (collectively, "Defendants") alleging they violated the federal FCA, as well as its New York and New Jersey state analogues,[148] by failing to report and return the Medicaid overpayments included in his spreadsheet within the appropriate amount of time.[149] Both the United States and New York elected to intervene in June 2012.[150] The United States sought treble damages plus an $11,000 penalty for each overpayment, while New York sought even more—treble damages plus a $12,000 penalty per overpayment.[151] Defendants moved to dismiss both the United States' and New York's Intervenor-Complaints on September 22, 2014.[152]

B. The Court's Analysis

The federal government argued that the Hospitals were liable under the FCA for reverse false claims.[153] Specifically, the government alleged that Kane's spreadsheet was alone sufficient to "identify" any overpayments contained therein simply because it put the Hospitals on notice of potential overpayments.[154] In the government's view, the Hospitals acquired an FCA obligation when they failed to report and return the listed overpayments within sixty days of receiving Kane's email.[155] To complete the Hospitals' FCA liability, the government argued that the Hospitals knowingly and improperly "avoided" their obligation by failing to follow up on Kane's

147. *Healthfirst*, 120 F. Supp. 3d at 383.

148. The New York State False Claims Act can be found at N.Y. STATE FIN. LAW §§ 187 *et seq.* (McKinney 2016). The New Jersey False Claims Act is set forth at N.J. STAT. ANN. §§ 2A:32C-1 *et seq.* (West 2016).

149. *Healthfirst*, 120 F. Supp. 3d at 378.

150. *Id.* The *Healthfirst* case is notable because it is the first time the government elected to intervene in an FCA suit predicated upon a violation of the Sixty-Day Rule. Scott R. Grubman, *Playing Hot Potato with Overpayments: Health Care Providers Must Act Quickly to Refund Overpayments or Risk FCA Liability*, AHLA CONNECTIONS, May 2015, at 18.

151. *Healthfirst*, 120 F. Supp. 3d at 379.

152. *Id.*

153. *Id.* at 378. The FCA's reverse false claims provision is 31 U.S.C. § 3729(a)(1)(G). *See supra* note 85 and accompanying text (discussing § 3729(a)(1)(G)). New York State also argued that the Hospitals violated the New York False Claims Act's analogous reverse false claims provision. *Healthfirst*, 120 F. Supp. 3d at 378.

154. *Healthfirst*, 120 F. Supp. 3d at 383. *See also id.* at 389 (noting that "[u]nder the definition of 'identified' proposed by the Government" the sixty-day clock begins to run once a provider is "put on notice of potential overpayments").

155. *Id.* at 383.

spreadsheet.[156] The Hospitals, in turn, argued that only overpayments of which they had actual knowledge should be deemed "identified," and that Kane's email was therefore insufficient to "identify" any overpayments because it at most indicated that all the listed claims were *potentially* overpaid, but did not definitively determine that any particular claim was *in fact* overpaid.[157] Thus, the court had to determine what Congress intended "identified" to mean in this context.

The court first concluded that the term "identified" "has no 'plain meaning' as it is used in the ACA."[158] Next, the court considered the legislative history of both the ACA and FERA. The Hospitals pointed to the fact that, in the ACA's initial incarnation in the House of Representatives, the Sixty-Day Rule's predecessor had required "known" (as opposed to "identified") overpayments to be reported and returned within sixty days.[159] As discussed previously, "known" has a specific meaning in the FCA, which incorporates both recklessness and deliberate ignorance.[160] Therefore, the Hospitals argued, Congress must have intended for "identified" to mean something different from "known" as it is used in the FCA, otherwise it would not have made the substitution.[161] From there, the Hospitals concluded that Congress must have used the term "identified" rather than "known" for the purpose of "exempt[ing] from FCA liability those healthcare providers who recklessly fail to uncover or remain deliberately ignorant of an overpayment."[162] In other words, the Hospitals argued that Congress's conscious use of "identified" in place of "known" meant that providers must have actual knowledge of overpayments before the sixty-day clock starts.

The court rejected the Hospitals' argument, finding legislative history from FERA to be more persuasive proof of congressional intent. The court focused in particular on a Senate Judiciary Committee report on FERA, which stated that an FCA obligation should exist "'where there is a relationship between the Government and a person that results in a duty to pay the Government money, whether or not the amount owed is yet

156. *Id.* at 393.
157. *Id.* at 384.
158. *Id.* at 385. The court looked to the dictionary for definitions of "identify," and determined that it is "susceptible to more than one meaning." *Id.* at 384–85.
159. *Id.* at 386.
160. *See* 31 U.S.C. § 3729(b)(1) (2012); *supra* notes 127–28 and accompanying text (discussing the meaning of "knowing" in the FCA).
161. *Healthfirst*, 120 F. Supp. 3d at 386.
162. *Id.*

fixed.'"[163] From this, the court concluded that Congress intended overpayments to be "identified" so long as "there is an established duty to pay money to the government, *even if the precise amount due has yet to be determined*."[164] Because the Hospitals had been placed on notice that *some* of the claims in Kane's spreadsheet had likely been overpaid, the court concluded those overpayments were immediately "identified" even though the Hospitals could not have known yet *which* had in fact been overpaid.[165]

The Hospitals protested that this interpretation of "identified" would produce an absurd result, in that it would subject the Hospitals to the "unworkable burden" of having to complete investigations into all of the 900-plus *potentially* overpaid claims included in Kane's spreadsheet within sixty days of receiving his email.[166] In particular, the Hospitals emphasized the rigorous review that would be needed to confirm each potential overpayment as an actual overpayment.[167] The court acknowledged that asking the Hospitals to repeat such a lengthy process more than 900 times over the course of sixty days could impose a "demanding standard of compliance . . . especially in light of the penalties and damages available under the FCA."[168] The court also conceded that a hospital might try its hardest to report and return all overpayments within sixty days of being put on notice, yet still fail and acquire an obligation.[169]

Despite these apparent and "potentially unworkable" burdens,[170] the court identified two reasons why it was willing to impose such an exacting standard on health care providers. First, the court noted that an FCA "obligation" does not automatically mean FCA liability; rather, even if a hospital reaches day sixty-one without returning an overpayment, the hospital must still do something more (*i.e.*, "knowingly conceal" or "knowingly and improperly avoid or decrease" the obligation) to become

163. *Healthfirst*, 120 F. Supp. 3d at 388 (quoting S. REP. NO. 111-10, at 14 (2009), *reprinted in* 2009 U.S.C.C.A.N. 430, 441). Even conceding that the legislative history of a statute may be used to interpret terms *within that same statute* (which some do not, *see, e.g.*, ANTONIN SCALIA & BRYAN A. GARNER, READING LAW: THE INTERPRETATION OF LEGAL TEXTS 56 (2012)), it stretches the concept of legislative history awfully thin to do what the court is doing here: using the legislative history of Statute A (FERA) to interpret a term contained in Statute B (the ACA).

164. *Healthfirst*, 120 F. Supp. 3d at 388 (emphasis added).

165. *See id.* ("Here, after the Comptroller alerted Defendants to the software glitch and approached them with specific wrongful claims, and after Kane put Defendants on notice of a set of claims likely to contain numerous overpayments, Defendants had an established duty to report and return wrongly collected money.").

166. *Id.*

167. *Id.* at 388–89. This review process was described *supra* in the text accompanying note 144.

168. *Healthfirst*, 120 F. Supp. 3d at 389.

169. *Id.*

170. *Id.* at 390.

liable under the FCA.[171] In cases involving "well-intentioned healthcare providers working with reasonable haste to address erroneous overpayments," the court argued that "prosecutorial discretion would counsel against the institution of enforcement actions," because such actions would be "inconsistent with the spirit of the law and would be unlikely to succeed."[172] This is really two separate arguments in one: (a) that a hospital making an earnest attempt at repayment is unlikely to have acted with the requisite scienter to sustain FCA liability; and (b) that prosecutors can generally be trusted not to bring weak cases. I criticize these arguments below, the former in Part III.A and the latter in Part III.B.3.

Second, the court offered a more forceful policy argument against requiring actual knowledge of overpayments for them to be "identified"—namely, that doing so would disincentivize hospitals from conducting any investigation at all after receiving an email like Kane's because, by never even attempting to gain actual knowledge, hospitals could dodge FCA liability while permanently retaining overpayments.[173] I refer to this as the "ostrich argument" because those who make it fear that, under an actual knowledge standard, providers would act like the proverbial ostriches and "bury their heads in the sand" to avoid learning of overpayments.[174] CMS used the ostrich argument to defend its decision not to adopt an actual knowledge standard, suggesting that providers might then "avoid performing activities to determine whether an overpayment exists, such as self-audits, compliance checks, and other additional research."[175] Another district court has also raised this policy concern in the context of a Medicare overpayment FCA case.[176] I respond to the ostrich argument *infra* in Part IV.[177]

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171. *Id.* at 389.

172. *Id*.

173. *Id.* at 390.

174. *See id.* (referring to a healthcare provider that tries to avoid learning about overpayments to stave off FCA liability as "putting its head in the sand"); 132 CONG. REC. H9382-03 (daily ed. Oct. 7, 1986) (statement of Rep. Berman) (stating that the term "reckless disregard" is "intended to reach the 'ostrich-with-his-head-in-the-sand' problem where government contractors hide behind the fact that they were not personally aware that such overcharges may have occurred"). The notion that ostriches bury their heads in the sand when threatened is apocryphal. They actually fall down and remain still so that their light-colored heads camouflage with the ground. *See Ostrich*, SAN DIEGO ZOO, http://animals.sandiegozoo.org/animals/ostrich (last visited Feb. 10, 2017).

175. Reporting and Returning of Overpayments, 77 Fed. Reg. 9179, 9182 (proposed Feb. 16, 2012).

176. United States v. Lakeshore Med. Clinic, Ltd., No. 11-CV-00892, 2013 WL 1307013, at *4 (E.D. Wis. Mar. 28, 2013) ("If the government overpaid defendant for [evaluation and management] services and defendant intentionally refused to investigate the possibility that it was overpaid, it may have unlawfully avoided an obligation to pay money to the government.").

177. In addition to these two main arguments, the court also noted that it considered but "d[id] not place significant weight upon" CMS's proposed rule for Medicare Parts A and B, as well as CMS's final

After the court established that the overpayments had been "identified" for purposes of the Sixty-Day Rule, the court went on to conclude that the government had successfully alleged the Hospitals knowingly and improperly avoided the resulting obligation.[178] Thus, the government's pleadings, accepted as true, survived the Defendants' motion to dismiss.[179]

In sum, *Healthfirst* imposes a burden on providers that the court itself acknowledges may be difficult (or sometimes impossible) to meet, and threatens failure to meet this burden with the possibility of severe FCA liability. It does so because, in the court's view, (a) the legislative history of FERA compels this result; (b) well-intentioned hospitals will likely not have acted with the scienter necessary for FCA liability; (c) prosecutors can be trusted not to pursue weak cases; and (d) otherwise, providers might avoid repaying by putting their heads in the sand. This opinion was the only one generated by the *Healthfirst* litigation, because one year after the court denied the Hospitals' motion to dismiss, they agreed to pay the government $2.95 million to settle the case.[180]

III. DISCUSSION

In this Part of the Note, I first discuss in Section A how a provider in a situation similar to that of the *Healthfirst* Hospitals could acquire an obligation if the A and B Rule applied. Next, in Section B I discuss three problems with the existing regulatory standards for when overpayments are "identified."

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rule for Medicare Parts C and D. *See Healthfirst*, 120 F. Supp. 3d at 391–393. Neither of these rules require actual knowledge of an overpayment for it to be "identified." *See supra* notes 109–12 and accompanying text. The court observed that, although these rules were without legal effect as to overpayment of *Medicaid* claims, still its conclusion was "at least consistent" with CMS's Medicare rules. *Healthfirst*, 120 F. Supp. 3d at 393. So while none of CMS's rules would be directly controlling on a court faced with the same issue today, as here, they would likely be persuasive.

178. *Healthfirst*, 120 F. Supp. 3d at 393–95. The court found that "the plain meaning of 'avoid' includes behavior where an individual is put on notice of a potential issue, is legally obligated to address it, and does nothing." *Id.* at 394. Because the government alleged that Kane's spreadsheet put the Hospitals on notice of potential overpayments, and that the Hospitals then "did nothing further with [Kane's] analysis," this showing satisfied the government's obligation to plead "avoidance." *Id.* The court then reasoned that this avoidance was "knowing," based on: (a) the proposition that knowledge "may be alleged generally rather than with particularity" under Federal Rule of Civil Procedure 9(b); and (b) the bare conclusion that the Government had pleaded facts "consistent with recklessness or deliberate ignorance, not merely negligence." *Id.* at 395.

179. *Id.* at 400.

180. Press Release, Dep't of Justice, Manhattan U.S. Attorney Announces $2.95 Million Settlement With Hospital Group For Improperly Delaying Repayment Of Medicaid Funds (Aug. 24, 2016), https://www.justice.gov/usao-sdny/pr/manhattan-us-attorney-announces-295-million-settlement-hospital-group-improperly.

A. Applying the A and B Rule to Healthfirst

Healthfirst was a Medicaid case, meaning that none of CMS's rules applied. But how would a case with facts similar to *Healthfirst* be decided under the A and B Rule? In other words, might the A and B Rule create an obligation in the situation where someone notifies a provider of a set of Medicare Part A and B claims containing some that were probably overpaid, but the provider has not yet determined which, if any, were actually overpaid?

Recall that, under the A and B Rule, overpayments are identified when a provider "has, or should have through the exercise of reasonable diligence, determined that the [provider] has received an overpayment *and quantified the amount of the overpayment*."[181] The rule goes on to clarify that a provider should have both determined that it received an overpayment and quantified the overpayment "if the [provider] fails to exercise *reasonable diligence* and the [provider] in fact received an overpayment."[182] Furthermore, the rule explains that, to act with "reasonable diligence," a provider that receives "credible information of a potential overpayment" must assign "qualified individuals" to investigate the possibility of overpayment "in good faith and in a timely manner."[183] Therefore, if a provider fails to conduct an investigation "in good faith and in a timely manner" in response to receiving credible information about potential overpayments, the A and B Rule says the provider *should have* determined it received overpayments and quantified them, and thus deems the provider to have "identified" overpayments even if it lacks actual knowledge of which claims were overpaid and by how much.

It is not hard to see how a provider in the position of the *Healthfirst* Hospitals could "identify" overpayments under the A and B Rule, even if the provider (a) did not actually determine which were overpaid and by how much; and (b) believed it was conducting an adequate investigation in response to being notified of possible overpayments. Upon receiving a credible tip about a set of potentially overpaid Medicare Part A and/or B claims (like Kane's spreadsheet), the provider would then have to assign "qualified individuals" to conduct an investigation "in good faith and in a timely manner." This standard leaves a lot of room for the government to challenge the hospital's investigation after the fact if it winds up taking

181. 42 C.F.R. § 401.305(a)(2) (2016) (emphasis added).

182. *Id.*

183. Reporting and Returning of Overpayments, 81 Fed. Reg. 7654, 7661 (Feb. 12, 2016) (to be codified at 42 C.F.R. pts. 401 and 405).

longer than expected. For instance, the government (or a relator) might later dispute whether the people the hospital put in charge of the inquiry were actually "qualified." There might also be questions about whether the hospital's investigation was done "in good faith" and "in a timely manner." Presumably, if a hospital does literally everything within its power to expedite the investigation it will not get an obligation until it has actually quantified the amount of the overpayment. But there is a lot of gray area between a model hospital and a hospital that totally refuses to investigate. For example, a hospital might wait a few days or a week before beginning its investigation. Does such a delay make the hospital's investigation not "timely" or not in "good faith"? What if instead of waiting some amount of time before beginning its investigation, the hospital elects not to commit as much manpower to the investigation as the government or a relator claims it should have? Courts may have to decide cases where the government claims an investigation was not "timely" because the hospital committed only five employees when it should have assigned ten. Or perhaps the employees will have only worked twenty hours a week on the investigation when the government thinks a "timely" investigation would have required forty hours per week.

The point here is not to answer these difficult line-drawing questions. I merely aim to illustrate that the A and B Rule leaves the government and relators a lot of room to argue that a hospital's investigation was not reasonably diligent, and therefore that the hospital has acquired an obligation for purposes of the FCA. In fact, CMS conceded that the question whether a particular investigation was conducted with "reasonable diligence" would be open to interpretation on the unique facts of each case. In its comments to the A and B rule, CMS noted that Commenters on the proposed rule had asked for "more detail on how to judge what is 'reasonable' about a reasonable inquiry, such as taking into account the unique characteristics of the provider or supplier and the nature of the problem."[184] CMS responded by pointing to its definition of "reasonable diligence" in the final rule, and went on to explain that "the concept of 'reasonableness' is fact-dependent."[185] Of course, what seems "reasonable" to a provider during its investigation might be viewed differently by a court or jury after the fact.

To be sure, the A and B Rule is more favorable to providers than either the *Healthfirst* approach, which holds that overpayments are "identified"

184. Reporting and Returning of Overpayments, 81 Fed. Reg. at 7662.
185. *Id.*

once a provider is put on notice that they potentially exist,[186] or the C and D Rule, which makes overpayments "identified" when the provider "has determined, or should have determined through the exercise of reasonable diligence" that they exist, even if they could not yet have been quantified.[187] The *Healthfirst* court candidly admitted that its interpretation of the Sixty-Day Rule would "impose a demanding standard of compliance in particular cases" because

> an overpayment would technically qualify as an "obligation" even where a provider receives an email like Kane's, struggles to conduct an internal audit, and reports its efforts to the Government within the sixty-day window, but has yet to isolate and return all overpayments sixty-one days after being put on notice of potential overpayments.[188]

Similarly, under the C and D Rule, an overpayment is "identified" once the provider should have determined it exists, even if the provider did not have enough time to quantify it. The A and B Rule at least recognizes that even a reasonably diligent investigation may fail to quantify all overpayments within sixty days. Yet although the A and B Rule is better than the alternatives, its lack of an actual knowledge requirement still means a provider can acquire an obligation despite its good faith belief that it was conducting an adequate investigation.

Of course, as the *Healthfirst* court pointed out, "the mere existence of an 'obligation' does not establish a violation of the FCA."[189] A provider with an obligation must still knowingly "conceal" or "avoid" it to violate the FCA. The *Healthfirst* court speculated that when a hospital has truly tried its hardest to investigate potential overpayments, it would likely not have acted with the requisite scienter to turn its obligation into a violation of the FCA.[190] According to the court, in the situation where the hospital is "still scrambling" on the sixty-first day to diligently report and return overpayments, "the provider would not have acted with the reckless disregard, deliberate ignorance, or actual knowledge of an overpayment

186. *See* Kane *ex rel.* United States v. Healthfirst, Inc., 120 F. Supp. 3d 370, 388 (S.D.N.Y. 2015).
187. 42 C.F.R. §§ 422.326(c) (Part C); 423.360(c) (Part D).
188. *Healthfirst*, 120 F. Supp. 3d at 389.
189. *Id.*
190. *See id.* ("[I]n the reverse false claims context, it is only when an obligation is *knowingly concealed* or *knowingly and improperly avoided or decreased* that a provider has violated the FCA. Therefore, prosecutorial discretion would counsel against the institution of enforcement actions aimed at well-intentioned healthcare providers working with reasonable haste to address erroneous overpayments. Such actions would be inconsistent with the spirit of the law and would be unlikely to succeed.").

required to support an FCA claim."[191]

It seems uncontroversial that when a hospital conducts an all-out investigation from the moment it learns of potential overpayments, it has not recklessly disregarded its obligation to repay. However, it is possible that a hospital conducting a somewhat less vigorous investigation could be found to have recklessly disregarded an obligation. The federal courts of appeals have interpreted "reckless disregard" in the context of the FCA to mean "aggravated gross negligence" or "an extreme version of ordinary negligence."[192] While this standard is more protective of hospitals than ordinary negligence, it nevertheless leaves hospitals open to claims that they were grossly negligent in designing and carrying out their investigations, perhaps by starting too late, committing too few man hours, or otherwise planning the investigation poorly. Because "no proof of specific intent to defraud" is required for an action to be "knowing,"[193] it will be up to the finder of fact to determine how negligent an investigation is too negligent. This means that, under the A and B Rule, hospitals that are very sloppy but lack bad intent may nonetheless be exposed to crushing FCA liability.

B. Problems with Using the FCA to Incentivize Diligent Provider Claims Auditing

The FCA was originally designed to deter bad actors from defrauding the federal government. Hence its punitive sanctions.[194] But when it comes to Medicare and Medicaid overpayments, the FCA is used in a very different way today.[195] As *Healthfirst* and the foregoing discussion illustrate, a

191. *Id.* at 389–90.

192. United States v. Krizek, 111 F.3d 934, 941–42 (D.C. Cir. 1997). *See also* United States v. King-Vassel, 728 F.3d 707, 712–13 (7th Cir. 2013) (agreeing with *Krizek*); United States *ex. rel.* Farmer v. City of Houston, 523 F.3d 333, 338 & n.9 (5th Cir. 2008) (same); United States *ex rel.* Aakhus v. Dyncorp, Inc., 136 F.3d 676, 682 (10th Cir. 1998) (same); Urquilla-Diaz v. Kaplan Univ., 780 F.3d 1039, 1058 (11th Cir. 2015) ("Our sister circuits have uniformly described *reckless disregard* for purposes of the False Claims Act as akin to 'an extension of gross negligence' or an 'extreme version of ordinary negligence.'" (citing *Krizek*, 111 F.3d at 942, and *Farmer*, 523 F.3d at 338 & n.9)); Hagood v. Sonoma Cnty. Water Agency, 81 F.3d 1465, 1478 (9th Cir. 1996) (stating that "knowing" for FCA purposes requires more than "innocent mistake or mere negligence"). *Cf.* United States *ex rel.* Miller v. Weston Educ., Inc., 840 F.3d 494, 500 (8th Cir. 2016) (explaining that "knowingly false" statements do not include "'[i]nnocent mistakes and negligence,'" and therefore in order to be "knowingly false" a claim "'must be a lie'" (quoting United States *ex rel.* Onnen v. Sioux Falls Indep. Sch. Dist. No. 49-5, 688 F.3d 410, 413 n.2 (8th Cir. 2012))).

193. 31 U.S.C. § 3729(b)(1)(B) (2012).

194. *See supra* notes 64–71.

195. *Cf.* Krause, *supra* note 4, at 125 (observing that novel applications of the FCA to the health care industry "signal the government's willingness to invoke the FCA against activities that are increasingly far removed from traditional types of government procurement fraud").

hospital might in theory be found liable for the FCA's treble damages and sizable penalties despite never having acted with intent worse than gross negligence at any point in the claims or repayment processes. The FERA Amendments and the Sixty-Day Rule have thus expanded the FCA beyond its original use. No longer is the FCA used solely to punish and deter intentional fraudsters—in the Medicare and Medicaid context, it is now a tool to incentivize hospitals to diligently manage their claims auditing processes. The FCA, with its treble damages and large penalties, is the big "stick" the government can threaten to use against providers to convince them to thoroughly review Medicare and Medicaid payments.[196] As discussed previously, correctly submitting a Medicare or Medicaid claim can be exceedingly tricky.[197] Billing errors are often made in good faith simply because of the difficulty of compliance.[198] Today, however, "providers have discovered that billing errors once viewed as mistakes in need of correction, are now attacked as crimes that compel million dollar settlements."[199] Given that perfect compliance can be so difficult, it is worth asking whether the grave threat of prosecution under the FCA is the appropriate means of incentivizing thorough provider claims review. In this Section, I discuss three major problems with using the FCA in this role, at least as applied to hospitals that have not *intentionally* defrauded the government.

1. Reputational Harms and Provider Mistrust

One undesirable result of imposing FCA liability on hospitals that have not acted with bad intent, even if they *have* acted incompetently, is that it lumps together fraud and mismanagement. This has the potential to stigmatize hospitals as fraudsters, when in fact their only misdeed was not mounting a sufficiently diligent response after being notified of potential overpayments, which may have originally been caused by honest

196. *See* Krause, *supra* note 11, at 1367 (referring to the FCA as the "primary weapon in the fight against health care fraud").

197. *See* Reinhardt, *supra* note 30 (describing the "regulatory complexity" of Medicare as "unrivaled anywhere in the world"); *supra* notes 26–33 and accompanying text.

198. *See* Jost & Davies, *supra* note 4, at 294 ("[T]here are many uncertainties about the billing requirements imposed on providers, and doubtless, there are instances when well-meaning individuals with billing responsibilities are simply unable to parse these complexities.") (footnote omitted); Public Comment to CMS Proposed Rule, Fed'n of Am. Hosps., *supra* note 118, at 2 ("[I]n a program the size, magnitude, and complexity of Medicare, the reality is that there are ambiguities and uncertainties about applicable rules and guidance . . . . There also is the risk for human error given the intricate rules and large volume of Medicare billings hospitals submit.").

199. Meador & Warren, *supra* note 8, at 456.

mistakes.[200] Incompetence and malfeasance are, of course, very different. But the FCA does not distinguish between the two, meaning that a good faith violator of the Act will be the same as an intentional fraudster in the public's eyes. Mistaking the one for the other runs the risk of breeding resentment in the provider community because they are labeled as bad actors even for their good faith errors.[201]

The case for distinguishing unintentional noncompliance from intentional fraud is especially strong in view of the tremendous complexity of Medicare and Medicaid.[202] Since complying with these laws is not merely a matter of good intentions, even reasonably diligent hospitals may make errors in the claims submission process.[203] If a provider makes such an honest mistake, and then is guilty of nothing more than a grossly negligent investigation into the overpayment, it seems distinctly unfair to say it has "defrauded" the government. But because courts applying the FCA are constrained by statutory minimums with regard to both damages and penalties,[204] a provider will still face punitive sanctions for violating the FCA regardless of whether its actions consisted of, at one extreme, intentionally submitting claims to Medicaid for services never performed

200. *See* Public Comment to CMS Proposed Rule, Fed'n of Am. Hosps., *supra* note 118, at 2 ("[T]he Proposed Rule reads like a fraud and abuse enforcement policy, and creates an aura that every Medicare overpayment is the byproduct of suspicious behavior of providers and suppliers."); U.S. CHAMBER INST. FOR LEGAL REFORM, FIXING THE FALSE CLAIMS ACT: THE CASE FOR COMPLIANCE-FOCUSED REFORMS (2013) ("Being adjudicated liable for fraud may carry with it a stigma of quasi-criminal wrongdoing."), http://www.instituteforlegalreform.com/uploads/sites/1/Fixing_The_FCA_ Pages_Web.pdf.

201. *See* Krause, *supra* note 11, at 1368 (noting that the FCA's "enormous penalties" force hospitals to settle FCA allegations, even when those allegations are based on hospitals' "good faith interpretations of ambiguous health care regulations," thus "threaten[ing] to alienate the health care provider community"); Snyder, *supra* note 13, at 11 ("[T]he federal prosecutor in false claims cases is armed with what appears to be an arsenal of fraud deterrents. This regulatory gauntlet within which health care providers 'operate' is a source of frustration and concern for health care providers and their advocates.").

202. *See* supra notes 26–33 and accompanying text (discussing the complexity of Medicare).

203. *See* Belanger & Bennett, *supra* note 95, at 31 ("FCA liability based on the retention of overpayments by the government is a real issue for healthcare providers because they routinely file dozens if not hundreds of claims, tend to be paid in lump sum amounts with payments of many claims at once, and then have to credit each component of a large payment to individual patient accounts. The opportunities for unintended errors, given this volume of billing and accounting transactions, are legion."). As proof, consider the fact that the Recovery Audit Program uncovered 1.5 million improper claims in fiscal year 2013 alone. RECOVERY AUDITING IN MEDICARE FOR FISCAL YEAR 2013, *supra* note 32, at 11 tbl. 1. Even assuming that some of these were submitted with the intent to defraud, a significant number were likely submitted in error simply because of the difficulty of complying with the law.

204. Courts do have some discretion to adjust the amount of penalties imposed, but cannot go below the statutory minimum of $10,781 per false claim. *See supra* note 66. Courts also have discretion to reduce the FCA's treble damages if the defendant cooperates with the investigation, but again there is a statutory floor of "2 times the amount of damages which the Government sustains because of the act of that person." 31 U.S.C. § 3729(a)(2) (2012).

and then falsifying records to cover it up, or, at the other extreme, accidentally submitting an improper payment because of a software glitch and then implementing a five-person team to report and return the overpayments when a court determines that using fewer than fifteen was grossly negligent.[205] The hospital that sets out with bad intent and the hospital that devises an ineffective investigatory plan are both classified as fraudsters, whom the public will deride for depleting the public fisc. We ought to be concerned about the significant reputational harms done to hospitals that are labeled as violators of the FCA for making honest mistakes in managing complicated claims systems.[206]

2. *The FCA's Punitive Liability is Inappropriate When Applied to Grossly Negligent Providers*

As previously discussed, the basic problem the FCA addresses is that the government cannot prevent itself from being defrauded unless it knows it is being defrauded.[207] The FCA responds to this problem in two ways. First, it incentivizes those with information about fraud against the government to speak up.[208] Second, it aims to make penalties for fraudulent conduct large enough to outweigh the benefits fraudsters receive, thereby deterring fraud.[209] The Act thus serves two distinct (although related) functions: incentivizing those with information about already-committed fraud to come forward, and deterring those who would commit fraud in the future from doing so. The Act addresses the first problem through its *qui tam*

205. Thus, providers may perceive a mismatch between the FCA's immense financial penalties and the reprehensibility of their own conduct in submitting a mistaken Medicare or Medicaid claim. In the words of the Louisiana Hospital Association, using the False Claims Act to punish hospitals for billing errors "borders on extortion." Letter from Robert P. Murphy, Gen. Counsel, Gen. Accounting Office, to Hon. William M. Thomas, Chairman, Subcomm. on Health of the H. Comm. on Ways and Means & Hon. Jim McCrery, Subcomm. on Health of the H. Comm. on Ways and Means 15 n.30 (July 22, 1998), http://www.gao.gov/assets/200/199164.pdf.

206. Professor Krause suggests that one reason to be concerned about perceived unfairness in the application of the FCA to the health care industry is that it may cause providers "to question the legitimacy of the government's enforcement efforts," which in turn may lead to "greater noncompliance, necessitating the use of even more coercive enforcement mechanisms." Krause, *supra* note 4, at 210, 212.

207. *See* SYLVIA, *supra* note 54, § 1:4. For this Note's earlier discussion of the FCA's solution to this informational problem, see *supra* notes 55–71 and accompanying text.

208. *See* SYLVIA, *supra* note 54, § 1:14 ("From its inception, the Act's central premise has been that in order to address the lack of information about fraud, the Government must seek the public's assistance."); *supra* notes 56–63 and accompanying text.

209. *See* SYLVIA, *supra* note 54, § 1:14 (stating that the FCA's "increased damages and penalties" were "intended to make the cost of engaging in fraud much higher"); *supra* notes 64–71 and accompanying text.

provisions, and the second through its treble damages and penalties.

From a theoretical perspective, the problem with any definition of "identified" that does not require actual knowledge of overpayments is that it carries the potential for the FCA's severe, deterrence-minded penalties to be applied even in situations where deterrence may not be possible. In the quintessential case of fraud that the FCA's sanctions were designed to deter, the fraudster is consciously considering whether or not to engage in fraud. The FCA aims to influence this decision by convincing the potential fraudster that the costs of his actions will outweigh the benefits, thereby preventing the inchoate fraud from being completed.[210] In such a case, the FCA's heavy, extracompensatory damages clearly serve their intended function.[211]

In contrast, a hospital that has received Medicare or Medicaid overpayments may violate the FCA without ever intending to defraud the government. Of course, if the hospital is considering intentionally delaying repayment, or attempting to hide the fact of the overpayment to avoid its obligation to repay altogether, then the threat of FCA liability will likely alter its calculus. But, as demonstrated, the various interpretations of the Sixty-Day Rule may sweep in even those hospitals that violate the Act negligently rather than intentionally. For these hospitals, the potential for FCA liability may not alter their behavior for the simple reason that they are *already* doing what they believe is necessary to comply.[212] Indeed, the A and B Rule's nebulous "timely manner" standard provides so little guidance to providers about how quickly a given investigation must be completed that a provider can *never* be sure it is doing enough (unless, perhaps, it is literally expending all its compliance resources on one investigation). While at the margins the threat of FCA liability may encourage hospitals to commit more resources to overpayment investigations (which might result in better compliance), even the threat of onerous liability will not influence the behavior of a hospital that truly believes it is already conducting a "reasonably diligent" investigation.[213] For these providers, the FCA's

210. *See supra* note 70 and accompanying text.

211. *See* Jost & Davies, *supra* note 4, at 295.

212. *See id.* at 294 (noting that the use of fraud and abuse laws to police violations of complex health care regulations is less fair when "fraud and abuse laws permit[] civil or criminal liability based on *unintentional* conduct" (emphasis added)).

213. Jost & Davies argue that it is appropriate to subject reckless providers to civil fraud penalties because "the reckless provider must have been aware of the fact that he or she was taking some risk . . . and have been willing to disregard that risk." *Id.* at 295. They go on to argue that "[i]t is fair to burden a provider with the obligation to choose correctly, once it can be proved that the provider realized that he or she was at hazard of obtaining a benefit to which he or she was not entitled." *Id.* at 295–96. Under their view, once a provider realizes that it *may* be obtaining a benefit (like overpayments), we can fairly

punitive liability does not serve its intended deterrence function, but instead stigmatizes good faith provider conduct as "fraudulent" and provides the government (and any *qui tam* relator) with a large windfall.[214]

Moreover, to the extent that the threat of punitive sanctions may induce providers to be overly cautious and commit more resources to all investigations, this is not necessarily a desirable outcome. Because providers do not have unlimited resources with which to ensure they comply with health care laws, providers should be allowed to decide for themselves how to allocate scarce compliance resources.[215] If a provider is put on notice of potential overpayments that are very likely to have actually occurred, an all-hands-on-deck investigation may be warranted. But if the potential overpayments probably did *not* happen, a less vigorous response may be appropriate. By imposing the vague standard of a "timely" investigation, and aiming FCA sanctions at investigations that fail to live up to this standard in a grossly negligent way, the A and B Rule threatens providers into expending maximum enforcement resources every time they are put on notice of a potential overpayment.[216]

The problem with this approach is that, in practice, providers cannot allocate maximum resources to each investigation. Some compliance activities must be prioritized over others. Suppose a provider makes a good faith decision to devote more resources to Investigation X than Investigation Y, even though Investigation Y is objectively more likely to involve actual overpayments. As a result, Investigation Y is not completed in a "timely

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sanction it for bad choices that it makes about how to investigate that possibility. But even if a provider knows it may have obtained an overpayment, it does not make sense to use *punitive* liability to punish the provider's subsequent good faith decisions that (a) are made under resource constraints, *see infra* notes 215–20 and accompanying text; and (b) the provider may not have even realized at the time would lead to an "untimely" investigation, and therefore are incapable of deterrence.

214. Nor will imposing punitive damages on a hospital that has tried in good faith to comply with the law serve the other purpose for imposing punitive damages, namely, retribution. *See* Pac. Mut. Life Ins. Co. v. Haslip, 499 U.S. 1, 19 (1991) (stating that "punitive damages are imposed for the purposes of retribution and deterrence"); RESTATEMENT (SECOND) OF TORTS § 908 (AM. LAW INST. 1979) ("Punitive Damages may be awarded for conduct that is outrageous, because of the defendant's evil motive or his reckless indifference to the rights of others."). When a provider has tried in good faith to meet its report and return obligations, it is difficult to say it acted with an "evil motive" or "reckless indifference to the rights of others."

215. *Cf.* Heckler v. Chaney, 470 U.S. 821, 831–32 (1985) (holding that courts should defer to executive agencies on how agencies choose to use their limited enforcement resources).

216. The *Healthfirst* standard, in contrast, would not ask whether the investigation was "timely," but instead only whether the investigation was completed within sixty days from when the hospital was put on notice of the overpayments. If not, the hospital would acquire an obligation. *See supra* note 186 and accompanying text. Thus, the *Healthfirst* standard also pressures hospitals to allocate resources in a particular way—namely, so as to ensure that all investigations can be completed within sixty days, regardless of how complicated they might be.

manner." Even if it was grossly negligent for the provider to think Investigation X deserved resources over Investigation Y, is this really the kind of decision for which we ought to impose *punitive* liability? This scenario is far afield from the classic fraud situation the FCA's punitive sanctions were originally intended to apply to, in which a calculating fraudster is considering whether to take advantage of an information asymmetry to defraud the government.[217] Here, by contrast, the provider may not have better information than the government about which claims were actually overpaid (at least, until it completes its investigation), and must make a judgment call about how to allocate its scarce resources. If the FCA is to be used in such a radically different way today, this policy judgment should at least be made by the popularly elected Congress, rather than through interpretations of a statutory term made by unelected judges and agency officials.[218]

A final problem with limiting provider discretion over how to allocate compliance resources is that overly thorough investigations drive up provider compliance costs even in cases where a less rigorous investigation might suffice.[219] If providers cannot pass these costs along to insurers, they will either have to absorb the costs themselves or increase the cost of the underlying health care. By threatening devastating liability based on uncertain standards, the Sixty-Day Rule and the FCA infringe on providers' discretion to allocate scarce compliance resources as they see fit, instead compelling them to err on the side of more expensive investigations every time.[220]

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217. *See supra* notes 69–71 and accompanying text.

218. *See* Indus. Union Dep't, AFL-CIO v. Am. Petroleum Inst., 448 U.S. 607, 686–87 (1980) (Rehnquist, J., concurring in the judgment) (arguing that Congress should not be allowed to "delegate important choices of social policy to politically unresponsive administrators").

219. In opposing the proposed A and B Rule, the Federation of American Hospitals argued that CMS's proposed definition of "identified" would "impose an unreasonable administrative burden on hospitals" because it might place providers under "a broad duty to conduct full-scale audits that go well beyond the statutory requirement to report and return overpayments." Public Comment to CMS Proposed Rule, Fed'n of Am. Hosps., *supra* note 118, at 7. The Federation continued: "This proposal will impose new infrastructure and expense obligations on hospitals that will increase the cost of health care services furnished to Medicare beneficiaries. . . . [It would also] essentially create a broad spectrum audit process without regard to whether an overpayment exists or not." *Id.*

220. *See* Public Comment to CMS Proposed Rule, Emory Healthcare, *supra* note 115, at 3 ("The proposed [A and B Rule] would interfere with processes we already have in place to address both routine and non-routine overpayments, and cause undue burden and the diversion and expenditure of unnecessary and scarce resources."); Public Comment to CMS Proposed Rule, Am. Med. Ass'n, *supra* note 115, at 1 (arguing that, by attempting to incentivize providers "'to exercise reasonable diligence to determine whether an overpayment exists,'" the proposed A and B Rule creates a "perpetual duty to 'research' whether any overpayment may exist" and a "boundless duty to troll medical records in search of innumerable vulnerabilities" (quoting Reporting and Returning of Overpayments, 77 Fed. Reg. 9179,

One might argue that the class of hospitals who conduct what they honestly believe to be "reasonably diligent" investigations, yet are grossly negligent and incur FCA liability anyway, is likely to be small enough that we should accept it as collateral damage of a rule that otherwise deters intentional fraud. And it is certainly true that it will sometimes be difficult to distinguish between, on the one hand, honest but incompetent investigations and, on the other, intentional efforts to delay or avoid repayment. However, that does not mean we should use a legal tool that treats the distinction as meaningless. The Sixty-Day Rule, as interpreted by the A and B Rule, C and D Rule, and *Healthfirst*, applies the same punitive sanctions not only to intentional failures to repay the government, but to grossly negligent efforts as well.[221] As a consequence, grossly negligent hospitals may face punitive liability designed to deter intentional fraud.[222] A better alternative would at least attempt to distinguish between negligent and intentional failures to repay, and reserve the most severe punitive penalties for the latter.

9182 (proposed Feb. 16, 2012))). *Cf.* Vt. Yankee Nuclear Power Corp. v. NRDC, 435 U.S. 519 (1978) (holding that courts cannot impose procedural rulemaking requirements above those mandated by the Administrative Procedure Act, in part because such "Monday morning quarterbacking" by courts would force agencies to always err on the side of using more procedures).

221. As previously noted, courts do have the power under the FCA to impose only double damages, rather than treble, and penalties as low as $10,781 per false claim on good faith violators. *See supra* note 204. But these sanctions are still too severe for a provider that has acted in good faith all along.

222. Of course, some negligent conduct may be bad enough to merit deterrence. In recognition of this fact, some states allow punitive damages to be imposed for grossly negligent conduct. *See* Christopher P. Flanagan & Christopher J. Seusing, *Punitive damages based on gross negligence: Massachusetts bucks the trend*, LEXOLOGY (Dec. 3, 2013) (noting that eight states allow punitive damages based on gross negligence and collecting cases), http://www.lexology.com/library/detail.aspx?g=ffda1144-270d-494b-9ea0-6aebecefa1d2. However, these states generally require the grossly negligent conduct to display certain aggravating characteristics before punitive damages can be imposed. *See, e.g.*, Valladares v. Bank of Am. Corp., 197 So. 3d 1, 11 (Fla. 2016) ("The character of negligence necessary to sustain an award of punitive damages must be of a gross and flagrant character, evincing reckless disregard of human life, or of the safety of persons exposed to its dangerous effects, or there is that entire want of care which would raise the presumption of a conscious indifference to consequences, or which shows wantonness or recklessness, or a grossly careless disregard of the safety and welfare of the public, or that reckless indifference to the rights of others which is equivalent to an intentional violation of them."); Peoples Bank of N. Ky., Inc. v. Crowe Chizek & Co. LLC, 277 S.W.3d 255, 268 (Ky. Ct. App. 2008) ("In a case where gross negligence is used as the basis for punitive damages, gross negligence has the same character of outrage justifying punitive damages as willful and malicious conduct in torts where the injury is intentionally inflicted."); Rogers v. T.J.X. Cos., 404 S.E.2d 664, 666 (N.C. 1991) (stating that, to be eligible for punitive damages, "[t]he tort in question must be accompanied by additional aggravating or outrageous conduct," which must include "evidence of insult, indignity, malice, oppression, or bad motive"). Thus, the type of negligent conduct that the states have deemed sufficiently blameworthy to warrant punitive damages seems to differ qualitatively from the conduct at issue here (*i.e.*, establishing inadequate procedures to return accidentally overpaid Medicare and Medicaid claims).

The bottom line is that the FCA was imported into the Medicare and Medicaid overpayment context because it was the heaviest-duty law available to convince hospitals to return overpayments quickly.[223] The potential for FCA liability probably frightens hospitals enough to investigate promptly in most cases. But so would a threat to blow to smithereens all hospitals whose investigations into overpayments are sufficiently substandard. By imposing onerous FCA sanctions even on hospitals that act without intent to defraud, the law levies the harshest punitive punishment even when it may not deter similar conduct in future,[224] and interferes with providers' discretion to allocate scarce compliance resources.

3. Prosecutorial Discretion and Settlement Leverage

Another important aspect of the FCA's application to the health care industry is that prosecutors now use it to reach large settlements.[225] In this light, reconsider the *Healthfirst* court's acknowledgement that its definition of "identified" could place health care providers under a "demanding standard of compliance in particular cases."[226] The court explained that it was comfortable with the risk that even some good faith providers might acquire FCA obligations because the fact that a hospital has an obligation does not mean it has already violated the FCA.[227] Rather, a hospital would still have to "knowingly conceal" or "knowingly and improperly avoid" the obligation to incur any liability under the FCA.[228] Thus, the court explained that "prosecutorial discretion" would discourage the government from

223. *See* S. REP. NO. 111-10, at 10, *reprinted in* 2009 U.S.C.C.A.N. 430, 437 (touting the FCA as "[o]ne of the most successful tools for combating waste and abuse in Government spending").

224. Punitive damages can also serve another function: to provide adequate incentives to sue when the amount of compensatory damages a plaintiff would recover is too small to induce enough plaintiffs to bring actions. *See* Exxon Shipping Co. v. Baker, 554 U.S. 471, 494 (2008) (noting that "heavier punitive awards have been thought to be justifiable . . . when the value of injury and the corresponding compensatory award are small (providing low incentives to sue)"). While it is certainly true that, at a certain point, low damages would provide inadequate incentives for *qui tam* plaintiffs to blow the whistle on hospitals that intentionally defraud the government, relators would still have ample incentive to sue even if their potential recoveries were considerably smaller than 15–30% of the vast liability hospitals can face under the FCA.

225. *See* Krause, *supra* note 4, at 126 (noting that "the majority of FCA cases are resolved through settlement rather than trial"); Meador & Warren, *supra* note 8, at 456 ("Health care providers have discovered that billing errors once viewed as mistakes in need of correction, are now attacked as crimes that compel million dollar settlements."); *supra* note 8 (cataloging some recent FCA settlements).

226. Kane *ex rel.* United States v. Healthfirst, Inc., 120 F. Supp. 3d 370, 389 (S.D.N.Y. 2015).

227. *See id.* ("[T]he mere existence of an 'obligation' does not establish a violation of the FCA.").

228. *See* 31 U.S.C. § 3729(a)(1)(G) (2012).

pursuing cases in which the provider was "well-intentioned."[229] According to the court, "[s]uch actions would be inconsistent with the spirit of the law and would be unlikely to succeed."[230]

For starters, an appeal to prosecutorial discretion is problematic in the context of the FCA because actions may be brought not only by prosecutors, but also by *qui tam* relators. Among new health care fraud actions filed under the FCA in 2015, 423 were *qui tam* suits, compared to just 25 non-*qui tam* suits.[231] Because relators may be "tempted more by the prospect of financial reward than by righteous indignation,"[232] a sense of "prosecutorial discretion" is less likely to restrain them from filing actions in cases where a government prosecutor might decline to do so. It is true that recoveries tend to be lower in cases where the relator goes it alone than in cases in which the United States intervenes.[233] Yet even if the chances of ultimate FCA liability are less when a relator prosecutes an FCA action on her own, the fact remains that *Healthfirst* and CMS's regulations, which do not condition obligations on actual knowledge of overpayments, make it easier for profit-driven relators to plead obligations.

This observation leads to a more fundamental point: an obligation alone may be intimidating enough to provide both prosecutors and relators with substantial leverage to force a settlement. Even if a prosecutor or relator is not confident that she can prove a hospital acted with the scienter necessary for liability, the fact that she can establish an obligation means the case can at least get past step one. Getting past step one increases the odds that a defendant will eventually be found liable for violating the FCA.[234] This

229. *Healthfirst*, 120 F. Supp. 3d at 389.

230. *Id.*

231. DOJ, Fraud Statistics—Health and Human Services, *supra* note 7. Taking all areas of enforcement into account, the *qui tam* to non-*qui tam* ratio for new matters filed in 2015 was 632 to 105. DOJ, Fraud Statistics—Overview, *supra* note 96.

232. Joan H. Krause, *Twenty-Five Years of Health Law Through the Lens of the Civil False Claims Act*, 19 ANNALS HEALTH L. 13, 16 (2010).

233. For health care cases in 2015, the government recovered $1.36 billion in settlements and judgments in cases where it intervened, compared with $468 million in cases where it declined to intervene. DOJ, Fraud Statistics—Health and Human Services, *supra* note 7. Across all FCA cases in 2015, the figures were $1.76 billion in cases where the government intervened and $1.15 billion when it declined. DOJ, Fraud Statistics—Overview, *supra* note 96. It is unclear whether this result is attributable to the fact that the government is more likely to intervene in strong cases, or to the potency of the government's advocacy when it intervenes. *Compare* Engstrom, *supra* note 18, at 1712 ("DOJ statistics have long suggested that intervened cases overwhelmingly generate recoveries while declined cases overwhelmingly end in dismissal. One common interpretation of this discrepancy is that DOJ selects cases on pure merits grounds such that the residuum of unintervened cases can be presumed meritless."), *with id.* at 1713 (noting that some argue that "the intervened-declined outcome discrepancy stems from the litigation leverage DOJ involvement brings").

234. Although, *how much* an obligation increases the odds of FCA liability will vary case to case.

increase in the likelihood of liability may be enough to force a rational hospital to settle.[235] Given the potentially massive amount of liability at stake in an FCA case,[236] including exclusion from future participation in Medicare,[237] defendants are especially unlikely to want to risk full FCA liability.[238] Because any bump in their odds of losing the case brings the end result of FCA liability that much closer, simply being able to establish an obligation may be enough to convince a hospital it is not worth it to carry the fight any further and risk the FCA's crippling sanctions.[239] The *Healthfirst* court ignored this reality when it posited that the FCA's scienter requirements would protect "well-intentioned" providers who acquire obligations. Indeed, in *Healthfirst* itself the parties settled for nearly $3 million one year after the court ruled the government had successfully pleaded an obligation.[240]

Furthermore, the *Healthfirst* court's suggestion that we can rely on

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In some cases, it may be obvious the provider lacked the scienter necessary for liability; in others, it may be a close call.

235. When faced with the prospect of an FCA suit, rational health care providers will consider the total amount for which they may be liable as the result of litigation, and multiply that amount by the probability that they will be found liable. The resulting sum, plus litigation costs, is the amount that the rational provider should be willing to settle the case for because, in theory, the price of settling and litigating is then the same. *See* Richard A. Posner, *An Economic Approach to Legal Procedure and Judicial Administration*, 2 J. LEGAL STUD. 399, 418 (1973) (stating that the maximum a defendant will agree to settle for "is the expected cost of the litigation to him and consists of his litigation expenses, plus the cost of an adverse judgment multiplied by the probability as he estimates it of the plaintiff's winning . . . minus his settlement costs"). Thus, the amount a provider should be willing to pay to settle a case is partially a function of the potential damages and penalties at stake (which are large in an FCA case). As the probability that a provider will be found liable increases—for example, because the government can plead an obligation—the amount for which the provider should be willing to settle increases accordingly. And as the possibility of FCA liability draws nearer, risk averse providers will be more likely to opt for settlement to avoid the full blow of the FCA's high damages and penalties.

236. *See supra* notes 13, 46–49 and accompanying text.

237. *See supra* notes 16–18 and accompanying text. The "death sentence" of exclusion can only be sought by the government once it intervenes, not by relators proceeding on their own. Consequently, government intervention in a *qui tam* action creates a powerful incentive for a provider to settle. Engstrom, *supra* note 18, at 1713.

238. *See* Krause, *supra* note 11, at 1368 ("[C]ritics now argue that the Act's enormous penalties give health care providers virtually no choice but to settle cases that could not be proven in court."); Krause, *supra* note 4, at 127 (same); Sage, *supra* note 4, at 1180 ("[L]arge organizations have such a large stake in avoiding exclusion from Medicare that they readily settle pending charges, making much of fraud control resemble a rebate program more than a law enforcement exercise."); Belanger & Bennett, *supra* note 95, at 38 ("It is the rare provider that can choose to eschew federal dollars and, therefore, the specter of a FCA case looms large."). As previously noted, hospitals may take the threat of exclusion from Medicare especially seriously because they rely on Medicare for a significant portion of their overall revenue. *See supra* note 17.

239. *Cf.* Belanger & Bennett, *supra* note 95, at 39 ("From a practical perspective, FERA and [the ACA] have tilted the balance of negotiating power decidedly in favor of the government.").

240. Press Release, Manhattan U.S. Attorney Announces $2.95 Million Settlement With Hospital Group For Improperly Delaying Repayment Of Medicaid Funds, *supra* note 180.

prosecutors to restrain themselves from prosecuting meritless cases may be too optimistic. Fighting fraud is politically popular.[241] If a federal prosecutor can report that her office has recovered taxpayer dollars by forcing a hospital to settle a claim that it fraudulently retained public money, she may reap a political advantage.[242] The public will likely not distinguish between, on the one hand, a hospital that was actively seeking to defraud the public by getting more than its fair share of government payments and, on the other, a hospital that accidentally received an overpayment, conducted a grossly negligent investigation, and was then strong-armed into settling to avoid the possibility of crushing liability.[243] The Department of Justice will issue a triumphant press release either way. Given this reality, we should not be surprised if prosecutors fail to exercise perfect restraint when tempted by the political incentive to pursue and settle borderline cases.

Another consideration is the recent proliferation of state versions of the federal FCA.[244] Because these state laws are directly inspired by the federal statute,[245] judicial interpretations of the federal act will likely influence interpretations of its state law counterparts. The danger for prosecutorial overreaching is even greater at the state level, where state prosecutors must actively seek reelection and are therefore likely to be even more finely attuned to the political consequences of their actions.[246] The political advantages of FCA settlements might be too much for state prosecutors to pass up. Especially when it comes to state FCAs, the *Healthfirst* court's

241. *See supra* note 4.

242. *See* Krause, *supra* note 11, at 1412 ("[F]ederal prosecutors—particularly the United States Attorneys—have strong personal incentives to apply the law in ways that benefit their personal agendas rather than the public good."); Golinkin II, *supra* note 4, at 317 (noting that federal prosecutors "have tremendous power that they are undoubtedly tempted to use in furtherance of their own personal agendas"). *But see* Richard S. Frase, *The Decision to File Federal Criminal Charges: A Quantitative Study of Prosecutorial Discretion*, 47 U. CHI. L. REV. 246, 249 (1980) ("[U]nlike most of his state and local counterparts, the federal prosecutor is not an elected official, and is not subject to popular political pressures, although he may be removed by the President.").

243. *See supra* Part III.B.1.

244. *See* SYLVIA, *supra* note 54, § 2:21 ("The success of the False Claims Act in obtaining recoveries for the United States has led a number of states and local governments to adopt their own versions of the Act."). *See also id.* § 12 (providing an overview of state false claims laws). For more on state false claims acts, see *supra* note 20.

245. *See* James F. Barger, Jr. et al., *States, Statutes, and Fraud: An Empirical Study of Emerging State False Claims Acts*, 80 TUL. L. REV. 465, 469 (2005) (noting that state false claims statutes are "modeled after" the federal FCA).

246. *See* Richard A. Posner, *Federalism and the Enforcement of Antitrust Laws by State Attorneys General*, 2 GEO. J.L. & PUB. POL'Y 5, 8–9 ("[S]tate attorneys general are politicians, that is, they are elected rather than appointed officials. . . . [T]he natural ambition of a politician who holds high state office is to be elected governor; hence, there is often . . . an incentive on the part of the attorney general to bring suits that confer a political benefit on him . . . . [And this leads attorneys general to bring] high-profile lawsuits that attract publicity to the attorney general . . . .").

assurance that providers can rely on prosecutorial discretion rings hollow.[247]

IV. THE SOLUTION: AN ACTUAL KNOWLEDGE STANDARD FOR "IDENTIFIED"

A better alternative to the existing interpretations of "identified" is a bright-line rule: overpayments should not be "identified" unless a provider has *actual knowledge* of both their existence and amount.[248] Under this standard, mere notice of potential overpayments would never qualify as an obligation. Rather, to acquire an obligation, a provider would need to have already done the work necessary to determine which claims were actually overpaid, and by how much. There would be no question of whether the hospital's investigatory efforts were "reasonably diligent" because the standard would look to results, not process. A provider could still violate the FCA by recklessly disregarding an obligation, but not until after the provider had acquired the obligation via actual knowledge of overpayments.

The major argument against requiring actual knowledge is the "ostrich argument" that such a standard incentivizes providers to remain deliberately ignorant of any overpayments they may have received.[249] This argument presupposes that nothing other than the FCA can adequately incentivize hospitals to diligently monitor for overpayments, a proposition with which some providers disagree.[250] The ostrich argument thus contemplates a stark choice: impose liability under the FCA, or impose no liability at all.

The response to the ostrich argument is to reject the false choice it offers. Although *some* sanctions are certainly necessary to deter providers from maintaining deliberate ignorance of overpayments, those sanctions need not be the exceptionally heavy sanctions provided for under the FCA. The FCA's serious punitive sanctions make sense for providers who have failed to act in the face of *actual knowledge* of both the existence and amount of

247. Concededly, when a federal court rules on a matter of federal law, any collateral influence its holding may have on state courts interpreting similar state laws is of only minor, if any, importance. The fact that state attorneys general may possess a strong political incentive to pursue and settle Medicaid overpayment cases under state false claims acts is an issue best addressed to the state legislatures that draft such statutes and the state courts that construe them.

248. The *Healthfirst* defendants made a similar argument. *See* Kane *ex rel.* United States v. Healthfirst, Inc., 120 F. Supp. 3d 370, 384 (S.D.N.Y. 2015).

249. *See supra* notes 173–76.

250. *See* Public Comment to CMS Proposed Rule, Univ. of Va. Med. Ctr., at 2 ("CMS believes it is necessary to [define 'identified' to include acting in deliberate ignorance or reckless disregard of the fact a hospital may have received overpayments] to create an incentive for . . . hospitals to report and repay overpayments. Such a view ignores the fact that hospitals are already subject to many government audits and reviews and already have many incentives to operate honestly."), https://www.regulations.gov/document?D=CMS-2012-0020-0060.

overpayments. For these providers, severe punitive sanctions are justifiable because they have at least acted with certain knowledge that they owed the government money, and, indeed, how much money they owed. Any choice to delay or avoid repayment in the face of such actual knowledge is the kind of conscious choice punitive liability is appropriate to deter.[251] But just because the FCA's "significant" and "'essentially punitive'"[252] sanctions are appropriate to deter *some* bad provider conduct, that does not mean they should be haphazardly applied to deter *all* undesirable provider conduct. For the reasons identified in this Note, the deterrence rationale does not justify applying the FCA's punitive liability to providers who have made an honest, but grossly negligent, attempt at timely repayment.[253] And since it can be difficult to distinguish the hospital that has *deliberately* avoided actual knowledge of overpayments from the hospital that has *negligently* done so, it would be better to apply the FCA's heavy punitive sanctions to neither, but instead to reserve the harshest sanctions for providers who have acted consciously in the face of actual knowledge of overpayments.

If CMS were to redefine "identified" to apply only to overpayments of which a provider has actual knowledge, Congress should then fill the gap with a more appropriate penalty for providers whose investigatory efforts are not "reasonably diligent," but who do not know for certain that they have received overpayments of a particular amount. Appropriate sanctions would not be as severe as under the FCA, because they would recognize that carelessness cannot be deterred to the same extent as conscious wrongdoing. Rather, appropriate sanctions for a provider whose efforts at repayment are substandard but who *does not* have actual knowledge of overpayments should be limited to: (a) the amount of the overpayments; plus (b) interest for the delay in repayment; plus (c) a percentage of the sum of the

251. *See* Knippen v. Ford Motor Co., 546 F.2d 993, 1002 (D.C. Cir. 1976) (noting that punitive damages "are awarded to punish and deter outrageous conduct, and the question is whether a defendant's conduct 'contains elements of intentional wrongdoing or conscious disregard' for plaintiff's rights" (quoting Nader v. Allegheny Airlines, Inc., 512 F.2d 527, 549–50 (D.C. Cir. 1975), *rev'd on other grounds*, 426 U.S. 290 (1976))).

252. Universal Health Servs., Inc. v. United States *ex rel.* Escobar, 136 S. Ct. 1989, 1995, 1996 (2016) (quoting Vt. Agency of Nat. Res. v. United States *ex rel.* Stevens, 529 U.S. 765, 784 (2000)).

253. *See supra* Part III.B.2. Punitive damages are, of course, properly used to deter wrongdoing that is difficult to detect. *See supra* notes 68, 70; BMW of N. Am., Inc. v. Gore, 517 U.S. 559, 582 (1996) (noting that higher punitive damages are justified "in cases in which the injury is hard to detect"). Since it is difficult for the government to detect Medicare and Medicaid overpayments, *see supra* note 55, this might seem to indicate that punitive damages are appropriately levied against providers who attempt to avoid their repayment obligations. However, as discussed previously, punitive damages will only change the calculus of providers who are *consciously considering* whether to engage in fraud. For those providers who make an honest, but grossly negligent, effort at timely repayment, punitive damages serve no justifiable purpose. *See supra* notes 210–14 and accompanying text.

overpayments and interest to reward the relator for her efforts in bringing suit.[254] Exclusion from Medicare and/or Medicaid should not be an option. This way, the government would be fully compensated for the amount it overpaid the provider. The relator would still have adequate financial incentives to sue. And, crucially, the provider would still have an incentive to conduct its investigation in a non-negligent manner in order to save the relator's share. But rather than a percentage of treble damages plus per-claim penalties, the relator's share would be limited to a percentage of the government's *compensatory* damages plus interest.

This solution responds to the problems identified in this Note. First, hospitals that did not actually know they were in possession of overpayments would face less stigma because they would be subject to lesser sanctions than intentional fraudsters. Second, the FCA's large punitive damages and penalties would still serve their appropriate function of deterring the most blameworthy provider conduct (*i.e.*, failure to act in the face of actual knowledge of overpayments), but would not apply to grossly negligent providers whose conduct is less capable of being deterred. Instead, providers without actual knowledge of overpayments could only be subject to lesser liability of between 115 and 130% of the amount of the overpayments (plus interest). Third, because an actual knowledge standard would preclude merely negligent providers from acquiring obligations, it would protect them from being strong-armed into large settlements in borderline cases by profit-seeking relators or politically motivated prosecutors. Finally, this bright-line rule would also have the benefit of certainty. A hospital could be assured that, unless it actually knows of the existence and amount of a given overpayment, it has not "identified" that overpayment and therefore cannot be liable for the FCA's serious penalties if it does not report and return within sixty days. This would restore providers' discretion to allocate scarce compliance resources. It would also ensure that providers no longer need to worry that investigations they honestly believe to be "reasonably diligent" are in fact not diligent enough to avoid the FCA.

CONCLUSION

For the federal government, cases based on health care providers' failure to report and return Medicare and Medicaid overpayments are a potentially

254. The current relator reward formula would do nicely: 15–25% of the government's recovery if the government intervenes, and 25–30% if the government does not. *See* 31 U.S.C. § 3730(d)(1)–(2) (2012).

bountiful new frontier. As recently as August 2015, the United States Attorney's Office for the Southern District of Georgia announced that it had reached "the first settlement under the False Claims Act involving a health care provider's failure to investigate credit balances on its books to determine whether they resulted from overpayments made by a federal healthcare program."[255] It was for $6.88 million. Because of the strength of the weapon Congress has provided the federal government to police the health care industry, it is crucial that it be properly calibrated. For the reasons identified in this Note, neither the A and B Rule, C and D Rule, nor *Healthfirst* have yet done so. Accordingly, CMS should reinterpret "identified" to require actual knowledge.[256]

Nicholas J. Goldin[*]

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255. Press Release, Dep't of Justice, Pediatric Services of America and Related Entities to Pay $6.88 Million to Resolve False Claims Act Allegations (Aug. 4, 2015), http://www.justice.gov/usao-sdga/pr/pediatric-services-america-and-related-entities-pay-688-million-resolve-false-claims.

256. CMS is free to change its interpretation in future, so long as it "show[s] that there are good reasons for the new policy" and "display[s] awareness that it *is* changing its position." FCC v. Fox Television Stations, Inc., 556 U.S. 502, 515 (2009).

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