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Health Law Alert

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U.S. Senate Approves Legislation That Spells Increased False Claims Litigation Against Health Care Industry

On December 21, 2005, the United States Senate completed work on the Deficit Reduction Act of 2005 (the "Act"). This expansive piece of legislation, which is expected to be approved by the House of Representatives and signed by the President, contains many provisions relevant to the health care community. Of particular importance are two sections of the Act that will likely increase the amount of fraud and abuse litigation brought against health care providers and suppliers by private individuals suing on behalf of states or the federal government. First, the Act imposes new employee education requirements on businesses who receive at least $5 million in annual Medicaid reimbursement. Among other things, qualifying businesses must educate their employees regarding federal and state whistleblower protection laws designed to deter fraud and abuse. Second, the Act contains certain financial incentives for states to enact false claims legislation similar to the federal False Claims Act ("FCA"). Although a number of states have already passed such legislation, many more will likely follow suit in order to obtain the financial incentives provided by the Act. Providers and suppliers must therefore remain vigilant in assuring that their business practices do not create potential liability under federal or state fraud and abuse laws.

Employee Education Requirements

Section 6033 of the Act creates new employee education requirements for businesses that receive at least $5 million in Medicaid reimbursement annually. In order to participate in a state's Medicaid program, qualifying entities will be required to establish written policies for their employees (including management), contractors and agents. These policies must include a detailed discussion of the FCA; federal administrative remedies for false claims and statements; applicable state laws pertaining to civil or criminal penalties for false claims and statements; and whistleblower protections provided under such laws. Moreover, a qualifying entity must include in any employee handbook a specific discussion of the rights of employees to be protected as whistleblowers, as well as the entity's policies and procedures for detecting fraud and abuse.

Requirements such as these are no doubt familiar to those who follow government efforts to combat fraud and abuse in federal health care programs, as they are akin to those found in many corporate integrity agreements entered into between the Office of Inspector General ("OIG") of the Department of Health and Human Services and health care businesses accused of fraud. What is new, however, is that these requirements are now being imposed on business entities that have not been accused of any wrongdoing whatsoever.

Encouraging Passage of State False Claims Legislation

At least sixteen states currently have laws similar to the FCA, as do the cities of Chicago and New York. The most prominent example of a state without such legislation is New York State, whose efforts to combat Medicaid fraud came under criticism in a series of front-page articles published in *The New York Times* during the summer of 2005. Partly in reaction to these reports, which themselves spurred an unscheduled investigation of the state's Medicaid fraud control unit by the OIG, section 6032 of the Act adds an entirely new section to title XIX of the Social Security Act in order to encourage the passage of state legislation similar to the FCA.

Under current federal law, when a state learns that a provider has received a Medicaid overpayment, the state must return a certain percentage of the amount overpaid back to the federal government within sixty days of discovering the overpayment. This process recognizes that Medicaid reimbursement is comprised of state *and* federal dollars. For example, wealthier states such as Connecticut and New York must return half of any overpayments back to the federal government, whereas a state such as Mississippi must only return twenty-four percent. As an incentive for states to pass legislation similar to the FCA, section 6032 of the Act allows states with qualifying legislation to return a smaller percentage of Medicaid overpayments back to the federal government. For example, if Connecticut, New York and Mississippi each had legislation that qualified under the Act, Connecticut and New York would only be required to return forty percent to the federal government, whereas Mississippi would return fourteen percent.

In order to qualify for this incentive, however, the state legislation must be reviewed and approved by the OIG, who is to act in consultation with the U.S. Attorney General. The OIG will review the legislation to confirm whether it meets certain requirements set forth in the Act. For example, the state legislation must contain a provision allowing for the filing of a complaint in state court by a private person acting on behalf of the state. Such persons, more commonly known as "*qui tam* relators" or "relators," must be allowed to file their complaint in secret for a period of no less than sixty days, during which time the state attorney general's office must be given an opportunity to review the complaint's allegations in order to decide whether it will take over the case. Furthermore, the Act requires that the state legislation include penalty provisions as strong as those in the FCA (i.e., recovery of three times the amount of the government's damages plus mandatory penalties of $5,500 to $11,000 for each false claim submitted).

According to the Act, the state legislation must also contain provisions that are "at least as effective [as the FCA] in rewarding and facilitating *qui tam* actions for false or fraudulent claims." Relators under the FCA are currently entitled to receive a percentage of the proceeds of the action or settlement of the claim, which percentage generally ranges from 15% to 30% depending on whether or not the government elects to intervene in the case. Therefore, at a minimum, the state legislation must contain similar language allowing the relator to share in any recovery.

Conclusion

These new provisions, which will become effective on January 1, 2007 if the Act is enacted as expected, have the potential to increase the amount of fraud and abuse litigation brought by private persons against health care businesses. First, as *qui tam* relators are often current or former employees, requiring that health care businesses educate their employees regarding fraud and abuse laws will likely increase the chances that even scrupulous health care businesses will be sued by opportunistic or disgruntled relators. Second, cash-strapped state legislatures that have not already passed false claims legislation are more likely to enact such legislation in order to receive the financial incentive provided by the Act, thereby providing an additional legal basis for relators to bring a claim against a health care provider or supplier. As a result, providers and suppliers must monitor their business practices vigilantly to avoid liability for false claims.

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