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Strengthening the relationship between DOJ attorneys and compliance professionals

an interview with
Michael D. Granston

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FEATURES

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COLUMNS

DEPARTMENTS

by Michael A. Morse, Esq., CHC

What compliance officers should know about state False Claims Acts

» 31 states and the District of Columbia have enacted false claims statutes that authorize *qui tam* whistleblowers to initiate and litigate false claims lawsuits.

» State false claims statutes provide a separate legal basis, independent of the federal FCA, for recovery in Medicaid fraud cases.

» Legal defenses that might be raised in federal FCA cases may not apply to claims under state false claims statutes.

» Develop an understanding of the resources, expertise, and priorities of those responsible for enforcing your state false claims statute.

» Develop a strategy for responding to state investigations, and avoid falling into the trap of focusing solely on federal inquiries.

Michael A. Morse *(MAM@Pietragallo.com) is a Partner of Pietragallo Gordon Alfano Bosick & Raspanti, LLP in Philadelphia.*

We are all now familiar with the stories of the recent record-setting recoveries by the United States Department of Justice in lawsuits filed under the federal False Claims Act (FCA). In fiscal year 2017 alone, the DOJ recovered more than $2.5 billion from FCA cases involving the healthcare industry, including drug companies, hospitals, pharmacies, laboratories, and physicians. Since 1986, when the *qui tam* provisions were added to allow private whistleblowers to file and litigate false claims cases, the DOJ has recovered a whopping $36.4 billion in FCA cases involving the healthcare industry. Of those recoveries, $30 billion came from lawsuits initiated by private *qui tam* whistleblowers, who received more than $4.9 billion in rewards for bringing those claims.

Morse

Often overlooked in those astounding federal recoveries, however, is the increasing importance of state false claims laws. Not only has the number of states with their own false claims statutes increased, but also the state investigators, auditors, and attorneys who enforce these state statutes have become more coordinated and sophisticated in their efforts to combat healthcare fraud. Understanding these state false claims laws is important for many reasons, including:

1. State FCAs provide a legal basis, separate from the federal FCA, for recovering funds defrauded from the Medicaid program or other state-funded healthcare programs;
2. State FCAs are not all alike, and the differences in these state laws deserve careful attention;
3. State FCAs are enforced by an impressive team of state attorney generals, and Medicaid Fraud Control Units are becoming increasingly sophisticated in their efforts to detect and combat healthcare fraud; and

4. Healthcare-related *qui tam* cases, especially those involving the Medicaid program, almost always include claims filed under the federal FCA and these numerous state false claims statutes.
5. For these reasons, it is essential that healthcare compliance professionals understand the provisions of their state false claims statute and how those statutes can impact healthcare compliance matters.

Proliferation of state false claims statutes

Although some states enacted false claims statutes decades ago, the proliferation of these state laws, along with their powerful *qui tam* whistleblower provisions, can be traced to the federal Deficit Reduction Act of 2005 (DRA). Section 6031 of the DRA, entitled *Encouraging the Enactment of State False Claims Acts* (commonly referred to as the State Incentives provision), enacted substantial new financial incentives for states to enact false claims laws that are modeled after the federal FCA.[1] If a state false claims statute is determined by HHS-OIG to meet certain enumerated requirements, the state is entitled to an increase of 10% in the state medical assistance share of any amounts recovered under that state false claims statute. In order to qualify for this financial incentive, the state must have in effect a law that meets the following requirements:

1. Establish liability to the state for false or fraudulent claims described in the federal FCA with respect to any expenditures related to state Medicaid plans described in Section 1903(a) of the Social Security Act;
2. Contain provisions that are at least as effective in rewarding and facilitating *qui tam* actions for false or fraudulent claims as those described in the federal FCA;
3. Contain a requirement for filing an action under seal for 60 days with review by the state attorney general; and
4. Contain a civil penalty that is not less than the amount of the civil penalty authorized under the federal FCA.[2]

As a result of these financial incentives, a growing number of state legislatures across the country enacted false claims laws that were modeled on the federal FCA. As of the end of 2017, 31 states and the District of Columbia have enacted false claims statutes that authorize *qui tam* whistleblowers to initiate and litigate false claims lawsuits (see Table 1 on page 26).

Additionally, the following states have enacted civil false claims laws that permit only that state, and not private *qui tam* whistleblowers, to file a lawsuit against those who submit false claims to state funded healthcare programs: Arkansas, Kansas, Maine, Nebraska, South Carolina, South Dakota, Utah, West Virginia, and Wisconsin. However, even in these "non-*qui tam* states," claims of Medicaid fraud are not out of reach for private whistleblowers. Instead, these Medicaid fraud claims can, and frequently are, filed under the federal FCA, because the Medicaid program is jointly funded by the federal and state government.

Important similarities and differences in the state false claims laws

Not surprisingly, there are many nuanced-differences between the 31 state false claims statutes—too many to catalogue in this article. That said, there are some important similarities and differences that should be kept in mind; if for nothing more than to emphasize the importance for compliance professionals to read and understand the provisions of the false claims statute in each state where their provider operates.

Table 1: States that allow whistleblowers to initiate and litigate false claims lawsuits[1]

State	False Claims Statute	DRA Compliant	Total 2017 Staff in Medicaid Fraud Unit
Alaska	AS09.58.010	N/A	12
California	Gov. Code § 12650	Yes	240
Colorado	CRS 25 5-4-303.5	Yes	16
Connecticut	CT Gen. Stat. 17b-301a	No	13
Delaware	6 Del. C. 1201	No	18
Dist. of Columbia	DC Code 2.308.15	No	20
Florida	F.S. 68.081-68.09	No	203
Georgia	O.C.G.A. 49-4-168	Yes	45
Hawaii	H.R.S. 661-21	Yes	15
Illinois	305 ILS 5/8A-3	Yes	44
Indiana	IC 5-11-5-5-2	Yes	57
Iowa	Iowa Code Ch.685	Yes	10
Louisiana	LA RS 46.4371.1	No	66
Maryland	Health Gen. 2-603	No	39
Massachusetts	M.G.L. c.12, §5A	Yes	37
Michigan	MCL 400.612	No	31
Minnesota	Minn. Stat. 15C	Yes	23
Montana	MCA 17-8-403	Yes	9
Nevada	NRS 357.010	Yes	19
New Hampshire	RSA 167:61-b	No	8
New Jersey	NJSA 2A:32-1	No	30
New Mexico	NMSA 1978 §30-44-1	No	25
New York	State Fin. Law 187-194	Yes	308
North Carolina	NCGS 108A-70.10, 1-605	No	51
Oklahoma	63 O.S. 5053	Yes	30
Rhode Island	RIGL 9-1.1-4	Yes	12
Tennessee	TCA 71-5-181	Yes	39
Texas	THRC Ch.36	Yes	196
Utah	Utah Code 26-20-9.5	N/A	13
Vermont	32 V.S.A. 631.632(b)	Yes	9
Virginia	V.A. Code 32-1-312, 313	Yes	102
Washington	RCW 74.09.210(2)	Yes	39.5

1. See NAMFCU: 2018 Statistical Survey of State Medicaid Fraud Control Units. Available at http://bit.ly/2LpLUbS

Similarities

In terms of the key similarities, perhaps most important is that each of these 31 state statutes provides a separate legal basis, independent of the federal FCA, for recovery against those who submit, or cause the submission of, false claims to the Medicaid program. Although DOJ and the states work together on investigating and litigating Medicaid fraud cases, the fact that state false claims statutes provide an independent basis for recovery is important for several reasons.

First, even if the federal government declines to intervene in a case, the states can independently elect to intervene and litigate a case. This is not merely a theoretical

possibility. I have personally been involved in numerous cases where one or more states have intervened, litigated, and settled cases even after the DOJ declined to intervene under the federal FCA. These cases demonstrate that healthcare providers cannot simply adopt a strategy of focusing only on federal investigators, thinking that they are "in the clear" if they convince the DOJ to decline a federal FCA case. Rather, prudence demands that providers respond thoughtfully and consistently to both federal and state investigators.

Second, the legal precedent that governs the federal FCA does not necessarily control claims brought under state false claims statutes. For example, it remains largely unsettled as to whether, and to what extent, the United States Supreme Court's landmark decision in *Universal Health Services v. United States ex rel. Escobar,*[3] addressing the issue of materiality under the federal FCA, applies to claims brought under the 31 state false claims statutes. Therefore, various legal defenses (including materiality, falsity, first-to-file, statute of limitations, and public disclosure) that might be raised against federal FCA claims may not apply to claims under state false claims statutes.

Third, the 31 state false claims statutes each contain investigative powers similar to the Civil Investigative Demand (CID) powers that the DOJ enjoys under the federal FCA. As a result, these states have the power, under the false claims statutes, to subpoena documents and, in many cases, to compel sworn deposition testimony. Even if a healthcare provider has responded to a federal subpoena or CID, it could nonetheless still receive an additional subpoena for information under a state false claims statute. Thus, healthcare compliance professionals should study the investigative provisions of their applicable state false claims statute so that they can effectively and properly respond to both federal and state demands for information.

Fourth, the 31 state false claims statutes each require that the state attorney general approve the dismissal of a *qui tam* whistleblower case filed under that state's statue. These provisions most frequently come into play when a *qui tam* whistleblower and a defendant attempt to settle a false claims case. Any such, settlement will require the approval of the attorney general of each state that has been named in the false claims lawsuit. Although this seems straightforward, the process of presenting the settlement and obtaining approval from each of the named states takes time. One way to shorten the approval time is to regularly update the states on the status of the litigation, and provide them with a candid assessment of the evidence and the prospects for settlement.

Moreover, in cases where claims have been filed under the federal FCA and state false claims laws (the typical case in the healthcare arena), the federal government and the states will require separate written settlement agreements. As a result, defendants must be prepared to negotiate settlement terms with both the DOJ and the attorneys general of the named states. However, as discussed below, when multiple states are named in the lawsuit, the states work together, through the National Association of Medicaid Fraud Control Units (NAMFCU), to have one or two states negotiate a global settlement agreement on behalf of all applicable states.

Differences

These similarities are important, but these 31 state false claims statutes are by no means identical. The state false claims statutes differ in several notable ways. First, although most state false claims statutes are limited to claims presented to the state, New York's false claims statute extends further to cover

claims presented to local governments as well.

Second, most state false claims statutes require a defendant to pay only the *qui tam* whistleblower's reasonable attorney's fees and costs, but Virginia and New York also require that a defendant pay the state's costs as well.

Third, most state false claims statutes mirror the federal FCA and mandate that the government investigate *qui tam* complaints, but New York's false claims statute states only that the state and local government "have the authority" to investigate.

Fourth, although the state false claims statutes that have been certified by HHS-OIG as compliant with the DRA generally mirror the federal FCA, nine state false claims statutes have not been certified as DRA compliant (as of mid-2018). Some of these states are working on legislative amendments to receive DRA certification, but until that occurs, it is important to recognize that these nine state false claims statutes differ materially from the federal FCA and the DRA-compliant state false claims laws. One helpful resource to understand these differences is the State False Claims Review section of HHS-OIG's website, which includes the OIG's assessment of 29 of the state false claims laws.[4]

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Enforcement of state false claims statutes

Developing an effective understanding of your state's false claims statute depends not only on knowing the specific language of your state's statute, but also in understanding the resources, expertise, and priorities of those responsible for enforcing that statute.

In general terms, the 31 state false claims statutes each grant the state attorney general broad authority to investigate, litigate, and resolve lawsuits filed under their respective false claims statute. Not surprisingly, however, these 31 states have differing levels of resources, expertise, and priorities when it comes to enforcing their false claims statute in healthcare cases.

As noted above, when multiple states are named in a Medicaid fraud lawsuit, as frequently occurs, the states work together on the case, through the NAMFCU. NAMFCU does not represent just the 31 states with false claims states; it represents 49 states and the District of Columbia. NAMFCU's Global Case Committee (GCC) manages the Medicaid fraud cases investigated, litigated, settled, or otherwise handled by NAMFCU. The GCC typically appoints one or two states to act as the representative of all NAMFCU's members in Medicaid fraud cases that involve more than one state. Those representative states take the lead in investigating, litigating, settling, and handling their appointed case on behalf of all NAMFCU states. Through this process, state Medicaid programs maximize their resources, avoid duplication of effort, and, perhaps most importantly, negotiate with health providers for global resolutions of all potential Medicaid liability at issue in the lawsuit. In 2017 alone, this GCC process resulted in total state Medicaid recoveries of more than $290 million.[5]

These results demonstrate that the NAMFCU and its GCC are becoming increasingly efficient and experienced in their work

combatting Medicaid fraud, waste, and abuse. By way of several examples:

1. NAMFCU teams are now using sophisticated claims data analytical tools, which allow for more rapid and effective investigations;
2. NAMFCU teams have access to a deep bench of investigators with substantial experience in Medicaid Fraud matters; and
3. NAMFCU has substantially reduced the time it takes to finalize global resolutions, through the use of standard settlement agreements with providers and whistleblowers, and a much more streamlined process for the settlement payments and whistleblower rewards.

Conclusion

Due to the growing number of state false claims statutes, and the sophisticated resources of the NAMFCU teams, states will continue to have an even greater impact in future healthcare compliance investigations and civil fraud matters. Compliance professionals must take care to:

- learn the requirements of their own state's false claims law;
- understand how their state false claims law differs from the federal FCA;
- know who is managing the investigation/litigation on behalf of the States; and
- develop a strategy for responding to that state investigation, and avoid falling into the trap of focusing solely on federal inquiries.

Paying attention to these issues will enable healthcare providers to better prepare for, and respond to, the growing number of lawsuits filed under state false claims laws.

1. Deficit Reduction Act of 2005 (DRA). Section 6031. Chapter 3. Available at http://bit.ly/2LO6wGI (page 70)
2. 42 U.S.C. § 1396h(b). OIG: State False Claims Act Reviews. Available at http://bit.ly/2OdRf3A
3. 136 S. Ct. 1989 (2016). *Universal Health Services, Inc. v. United States ex rel Escobar et al.* Available at http://bit.ly/2rC1abg
4. Ibid, Ref #1.
5. See NAMFCU 2017 Annual Report., Available at http://bit.ly/2LpYTKN