Saint Louis University Health Policy Legislative Analysis Team[1]
MISSOURI STATE HEALTH POLICY BRIEF #4
For the Missouri Foundation for Health (MFH)

Analysis of Missouri Senate Bill 1210: Medicaid Fraud Legislation

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Missouri Senate Bill 1210 responds to recently-enacted federal law designed to induce states to pass False Claims Act laws by increasing by 10% the share of money states would receive from Medicaid fraud settlements. The act would clarify and probably broaden the legal standard for obtaining convictions, would increase criminal penalties, and would establish a qui tam "whistleblower" law to encourage private parties to uncover and challenge Medicaid fraud. This Policy Brief describes the legislation, analyzes its provisions and rationale, and concludes by assessing how the proposed legislation would affect the Medicaid program in Missouri.

Background

False claims actions have been responsible for very significant government recoveries at the federal level, particularly in health care. According to a recent GAO Report, since Congress amended the False Claims Act (FCA) in 1986, the government has won recoveries of over $15 billion from fiscal years 1987 through 2005.[2] Of the $15 billion, 64 percent, or $9.6 billion, was for recoveries associated with cases filed by whistle blowers under FCA's qui tam provisions. Health care fraud cases were the largest category of cases pursued by the Department of Justice and the Department of Health and Human Services was the agency most frequently named as being defrauded in false claims cases. A number of prominent cases have been the product of fraud uncovered by private parties filing qui tam suits, such as the case involving TAP Pharmaceuticals, which settled criminal and civil charges paying over $900 million in 2001. Many other qui tam suits have involved kickbacks, upcoding and overbilling by health care providers.

Medicaid fraud cases have included various schemes by pharmaceutical manufacturers and providers such as the $233 million settlement with Bayer in which the government alleged defendants knowingly misreported its best price and underpaid

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[2] General Accounting Office, *Information on False Claims Litigation: Briefing for Congressional Requesters* (Dec. 15, 2005).

its Medicaid rebates by omitting certain "private label" prices. It is difficult to estimate the amount of losses due to Medicaid fraud; however the amount is undoubtedly substantial.[3] Despite the sizeable recoveries for fraud against the Medicare program, Medicaid fraud recoveries have been relatively small. According to one study, Medicare fraud recoveries have been 25 times greater than Medicaid recoveries; adjusting for the relative size of the two programs, Medicare fraud judgments and settlements area still 12 times greater than Medicaid. Assuming the difference is not explainable by material differences in the amount of fraud in the two programs, one likely cause is differing incentives and procedural obstacles to bringing fraud cases.

The federal False Claims Act applies only to fraud against the federal government and therefore does not apply to the States' share of Medicaid spending. Thus even where fraud was proven against the Medicaid program, only the federal share of expenses was recoverable under the federal law; and states obtaining recoveries had to return to the federal government the federal share of such recoveries. (16 states have adopted state false claims laws to recover state losses). Case law establishes that relators'[4] false claims actions submitted for false costs reports cannot recover the federal share of the costs under the Federal FCA, [5]and in most states, relators cannot recover on a state law claim unless the state has passed a state qui tam action.

In February 2006, Congress enacted the Deficit Reduction Act of 2005, which added section 1909(b) to the Social Security Act to encourage the remaining States to pass their own versions of the federal False Claims Act. Section 1909(b) offers the States a strong incentive to enact a state False Claims Act. Specifically, a State that has in effect a qualifying False Claims Act is entitled to an increase of ten percentage points in the share of any amounts recovered under an action brought under the Act. For example, according to one research report, Missouri's share of 38.4% would increase to 48.4%.[6]

In order to qualify for this increase, the new law requires that a State must demonstrate to the Inspector General of the U.S. Department of Health and Human Services (OIG) that its False Claims Act complies with the following requirements:

(1) establishes liability to the State for false or fraudulent claims.[7]

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[3] One estimate extrapolates from estimates of Medicare "overpayments" for 2001, placed Medicaid overpayments at $9.6 billion, the state share of which was $4.1 billion; the estimate did not break down the proportion attributable to fraud. Andy Schneider, *Reducing Medicaid Fraud: The Potential of the False Claims Act* (Taxpayers Against Fraud Education Foundation 2003) at 15.

[4] Andy Schneider, *Reducing Medicaid Fraud: The Potential of the False Claims Act* (Taxpayers Against Fraud Education Foundation 2003) at 8.

[5] *United States ex rel. Woodard v. Country View Care Center, Inc.,* 797 F.2d 888 (10th Cir. 1986),

[6] Taxpayers Against Fraud Education Foundation, *Cash Back for State Action*, available at http://www.taf.org/cashbackstatefca.htm

[7] described in section 3729 of title 31, United States Code, with respect to any expenditure described in section 1903(a)

(2) contains provisions that are at least as effective in rewarding and facilitating *qui tam* actions for false or fraudulent claims as those described in current law;[8]

(3) contains a requirement for filing an action under seal for 60 days with review by the State Attorney General;

(4) contains a civil penalty that is not less than the amount of the civil penalty authorized under current law[9]

Provisions of Proposed Legislation

In order to meet the requirements of DRA 2005, SB 1210 contains important revisions to its state false claims law and adds a new qui tam statute. In general, the act strengthens enforcement against false claims by broadening the substantive reach of the law, increasing penalties and expanding the opportunity for detection and prosecution of fraud.

First, the act provides a more complete definition of the requisite mental state necessary for liability under the false claims act, adopting the definition used by the federal FCA and the statutes of many states. This act provides that a person commits a "knowing" violation of sections prohibiting Medicaid fraud if he or she has actual knowledge of the information, acts in deliberate ignorance of the truth or falsity of the information, or acts in reckless disregard of the truth or falsity of the information

Second, SB1210 increases penalties for false claims. Whereas current law provides that any person committing such a violation shall be guilty of a Class D felony upon a first conviction, and shall be guilty of a Class C felony upon subsequent convictions, SB1210 increases the standard to that of a Class C felony upon a first conviction, and a Class B felony upon subsequent convictions. (Class B felonies carry imprisonment terms from 5-15 years; Class C felony terms are not to exceed 7 years; and Class D felonies carry terms not to exceed 4 years). Importantly, the act also adds a provision that provides any “natural person” convicted shall be forever excluded from participation as a Medicaid provider. (This means a corporate provider would not automatically be permanently excluded; the legislation is silent on what standards might apply). Also, it requires that persons convicted serve at least 85 percent of any term of imprisonment ordered as punishment and adds criminal penalties of a class D felony and exclusion for any certain acts obstructing or interfering with communicating information about such violations of the law.

Third, the act adopts qui tam law and whistleblower protection to encourage detection and enforcement of the state false claims law. This law allows individuals (called “relators”) to bring an action for Medicaid fraud on behalf of the person and the state. The person bringing the action must give a copy of the petition to the attorney general, and must also disclose to the Attorney General all material information in the person’s possession. The petition shall be filed in camera, and shall remain under seal

[8] Sections 3730 through 3732 of title 31, United States Code

[9] Section 3729 of title 31, United States Code.

for at least 120 days, or until the state elects to intervene, whichever occurs first. Service of the petition shall not be made on the defendant until ordered by the court. The attorney general may elect to intervene and proceed with the action, not later than 120 days after the date the attorney general received the petition and information. The person who initiated the action is entitled to 20 to 35 percent of the proceeds of any action brought under this section, unless the court finds that the action is based primarily on information not provided by the person initiating the action, in which case the court shall award the person no more than 15 percent of the proceeds.

The act incorporates a large number of procedural rules and other protections to this qui tam law. Unlike the federal qui tam law, SB1210 does not permit the relator to proceed with the case in the name of the state if the Attorney General (who has 120 days to review the merits of the suit) elects not to continue the litigation. Relators may not bring an action that is based on the public disclosure of allegations or transactions in a criminal or civil hearing, in a legislative or administrative report, hearing, audit, or investigation, or from the news media, unless the person bringing the action is the original source of such information. If the person bringing the action planned and initiated the violation on which the action is based, the court may reduce the share of the proceeds to the extent it deems appropriate; however, any person convicted of a violation shall not be entitled to any share of the proceeds, and shall be dismissed from the action. A person may not bring an action under this act that is based on allegations that are the subject of another civil suit or administrative penalty proceeding which has already commenced, and in which the state is a party.

Fourth, the act also contains "whistle-blower" protections, providing that a person who is discharged, demoted, suspended, threatened, harassed, or in any way discriminated against in terms of employment due to a lawful act taken by the person in furtherance of an action for Medicaid fraud shall be entitled to reinstatement with the same seniority status, not less than two times the amount of back pay, interest on the back pay, and compensation for any special damages sustained as the result of such discrimination. Limitations on such protections are provided such as if the employee brought a frivolous or clearly vexatious claim or planned, initiated, or participated in the conduct upon which the action is brought, or is convicted of criminal conduct arising from Medicaid fraud violations.

Finally, the act provides a variety of investigative tools to assist in detection of fraud and also provides that all Medicaid health care providers shall maintain adequate records regarding services provided, claims submitted, and payments requested, and shall maintain such records for at least five years.

Analysis of SB1210

- Missouri, as in other states, has strong incentives to pass legislation because the DRA 2005 allows states to keep an additional 10% of money recovered if the

State has a FCA in place.[10] Based on the level of federal-state sharing for FY 2007, this would increase Missouri's share of false claims recoveries from 38.4% to 48.4%.[11] Using data concerning settlements of five large federal false claims cases that were settled between 2001 and 2004, Missouri's share of those settlements under the new federal sharing formula would have been $16,962,000 instead of the $13,462,000 actually received.[12]

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- SB1210 provides many of the same incentives and protections for whistleblower suits that are provided under the federal qui tam statute. For example, courts may reduce or eliminate recovery for relators who have "planned, initiated or participated in the conduct" and no person convicted of a crime arising from the false claims statute may recover any share of proceeds or settlements. In addition, whistleblowers are afforded a measure of protection in their employment relationships under the new act. One difference from the federal law concerns the relators' potential gain: the range of possible recovery for qui tam plaintiffs is somewhat greater under SB1210 than that provided under federal law (i.e., 15-25% under federal law; 20-35% under SB1210[13]). This difference might be justified by the fact that the incentives to bring qui tam actions in Missouri may be less than at the federal level because they necessarily involve only a single state and may concern relatively small providers of care.

- SB1210 adopts the federal *mens rea* standard for violations of the false claims act, defining as acting "knowingly" those persons who act in deliberate ignorance or with reckless disregard to the truth or falsity of statements. Extensive litigation under the federal FCA over the meaning of these terms has broadened the scope of potential liability beyond situations in which the defendant has actual knowledge of the falsity of his claim to include situations in which providers act in "deliberate ignorance," or as one court put it, take the approach of an "ostrich with its head in the sand." See, e.g. United States v. Krizek, 111 F.3d 934 (1997). Prosecutors view this as an important weapon in guarding against fraud as it enables them to pursue litigation against individuals who deliberately shield themselves from direct knowledge of submission of false claims by their agents, but are fully aware of the consequences of the billing practices or other procedures accompanying their claims for reimbursement. Although there may be concern that the more sweeping definition will risk criminalizing accounting

[10] Note: the increase is an additional ten percentage *points*, rather than an increase of ten percent above the prior level.

[11] Taxpayers Against Fraud Education Foundation, *Cash Back for State Action*, available at http://www.taf.org/cashbackstatefca.htm

[12] A list of approximately 80 Medicaid fraud settlements and state recoveries can be found at Andy Schneider, *Reducing Medicaid Fraud: The Potential of the False Claims Act* (Taxpayers Against Fraud Education Foundation 2003) at 52-55.

[13] Federal qui tam law allows the relator to retain 25-30% of proceeds and settlements if the government does not intervene and the relator continues the litigation. SB1210 limits the relator to 15% if the court finds the action was based "primarily on disclosure of specific information that was not provided by the [relator]."

errors and mathematical mistakes, a number of federal cases have attempted to draw boundaries between "mistakes" and false statements and have required that the government demonstrate that a false statement was "material". See Luckey v. Baxter Healthcare Corp. 183 F.3d 730 (7th Cir. 1999). There is limited precedent interpreting the current *mens rea* standard in Missouri, see, e.g. Missouri v. Mann, 23 SW3d 824; it is likely that the more expansive federal standard would reach a broader range of conduct than would Missouri's current standard.

- The most controversial application of the false claims act in recent years has concerned cases brought by U.S. Attorneys alleging that failure to provide adequate care was a "false certification" or "implied false certification" and hence subjected providers to liability under the federal FCA. See, e.g. U.S. ex rel Mikes v. Straus, 274 F. 3d 687 (2d Cir. 2001). These cases have often involved nursing homes that engaged in complete dereliction of care resulting in death or severe injury to nursing home residents. Some commentators fault these prosecutions as an attempt to federalize or even criminalize medical negligence law. Others assert the cases are an important tool to uncover and penalize cases of extreme abuse, not only of patients but of state/federal funding sources.

- A salient consideration is whether the incremental cost of implementing MO FCA will be paid for from increased recoveries by the state. The Attorney General will doubtlessly expend considerable resources in monitoring qui tam actions and making his decision whether to proceed. As noted above, by enacting SB1210, the state stands to receive sizeable sums it would not otherwise receive from large national Medicaid fraud cases. In addition, based on the large number of cases uncovered by qui tam relators nationwide, it is likely that the new law will furnish incentives for detection and reporting of instances of fraud that might not otherwise come to the state's attention. In a Fiscal note attached to SB1210, Oversight Division estimates that the qui tam actions will cost the state, after federal reimbursement, an additional $114,000 -$125,000 each year for the next three years. This estimate includes cost of review and audit. In case there are criminal convictions resulting in incarceration the cost may increase by an additional $100,000. As noted above, in the five large cases that were settled, Missouri would have received an additional $3.5 million if both the DRA 2005 Federal incentive and an MO FCA were in place. Assuming that the frequency of qui tam actions and recoveries from such actions follow past history, it would be seem that the incremental revenue would exceed incremental cost by a rather significant margin.

Analysis of House Bill 2098

HB2098 has also been introduced to address Medicaid fraud and this legislation would make several minor changes to existing law:

- HB2098 adds to the categories of "abuse" punishable under the statute, "financial exploitation by any person, firm, or corporation" but does not define that phrase.

- Under HB2098, no person shall intentionally fail to cooperate with, obstruct, or make a false statement or misrepresentation of a material fact during an investigation conducted in accordance with section 191.910.

- HB2098 adds a provision making it a class D felony (first offense) and a class A felony second offense for anyone to "intentionally fail to cooperate with, obstruct, or make a false statement or misrepresentation of a material fact during an investigation conducted in accordance with section 191.910."

The failure to define "financial exploitation" suggests that the proposed bill will have little impact on the most serious forms of Medicaid fraud. [14] One cannot be confident that a provider or other who defrauds the Medicaid program through false or fraudulent billing will be found to have "financially exploited" a beneficiary of the program. Further, the absence of a qui tam provision and the failure to adopt the broader definition of "knowing" or knowingly makes it unlikely the bill will meet the requirements of DRA 2005 to qualify Missouri for enhanced sharing of proceeds in Medicaid fraud cases.

CONCLUSIONS

SB1210 responds to the invitation of DRA 2005 to enhance state false claims law governing Medicaid fraud. Based on past experience with the federal qui tam law, it is likely to create incentives for private parties to uncover and act upon instances of fraud that would not otherwise be discovered by law enforcement authorities. While it is impossible to predict the magnitude of the recoveries that will accrue to the states, it is notable that a large proportion (64%) of federal recoveries, including some of the very largest cases, were the product of whistleblower suits. Changes in Missouri's false claims law standard of intent are likely to broaden the reach of the law and address fraudulent behavior that might otherwise go unpunished.

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[14] Section 570 of the Missouri Code criminalizes financial exploitation of the elderly, which it defines as follows: A person commits the crime of financial exploitation of an elderly or disabled person if such person knowingly and by deception, intimidation, or force obtains control over the elderly or disabled person's property with the intent to permanently deprive the elderly or disabled person of the use, benefit or possession of his or her property thereby benefiting such person or detrimentally affecting the elderly or disabled person. VAMS 570.145.