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OIG Issues Updated Guidelines for Evaluating State False Claims Acts: Is More State Litigation on the Horizon?

RESOURCE LINKS

[Updated OIG Guidelines for Evaluating State False Claims Acts, issued in 2013](#)

[Original OIG Guidelines for Evaluating State False Claims Acts, issued in 2006](#)

On March 15, 2013, the U.S. Department of Health and Human Services' Office of Inspector General ("OIG") released the *Updated OIG Guidelines for Evaluating State False Claims Acts* ("2013 Guidelines"),¹ which replaces the original version released in 2006 ("2006 Guidelines"). The 2013 Guidelines describe OIG's methodology for determining whether a state's Medicaid false claims law satisfies the four requirements in Section 1909(b) of the Social Security Act ("Act") that are necessary to qualify for a 10-percentage-point increase in the state share of Medicaid-related false claims recoveries.

The 2013 Guidelines also provide more specific insight into OIG's review process when evaluating state false claims laws and are based on OIG's experience in reviewing over 28 different state false claims laws. Unlike the 2006 Guidelines, the 2013 Guidelines reflect the three amendments to the federal False Claims Act ("FCA") that have occurred since Section 1909 of the Act was passed.² Generally, these three amendments to the FCA, modified, in significant part, the bases for FCA liability; expanded the rights of *qui tam* relators; and added a requirement that civil monetary penalties ("CMPs") include adjustments under the Federal Civil Penalties Inflation Adjustment Act of 1990.³

Section 1909 of the Social Security Act

By way of background, Congress enacted Section 1909 of the Act on January 1, 2007, to encourage states to enact or update existing FCA legislation and vigorously combat Medicaid fraud, waste, and abuse.⁴ Specifically, Section 1909 of the Act, added by Section 6031 of the Deficit Reduction Act of 2005,⁵ empowers OIG, in consultation with the U.S. Attorney General, to determine whether state false

¹ U.S. Dep't of Health & Human Servs., Office of Inspector General, UPDATED OIG GUIDELINES FOR EVALUATING STATE FALSE CLAIMS ACTS, available at <https://oig.hhs.gov/fraud/docs/falseclaimsact/guidelines-sfca.pdf> (hereinafter "GUIDELINES"). The GUIDELINES are effective on March 15, 2013, and replace the earlier version effective on August 21, 2006. See 71 Fed. Reg. 48552 (Aug. 21, 2006).

² Congress has amended the FCA three times since the enactment of section 1909 of the Act: the Fraud Enforcement and Recovery Act of 2009 (May 20, 2009), the Patient Protection and Affordable Care Act (March 23, 2010), and the Dodd-Frank Wall Street Reform and Consumer Protection Act (July 21, 2010). The FCA, as amended, is codified at 31 U.S.C. §§ 3729–33.

³ See 31 U.S.C. § 3729(a).

⁴ See GUIDELINES, at 3.

⁵ Pub. L. No. 109-171 (2005).

claims statutes meet the Act's requirements and thus qualify for a 10-percentage-point increase in a state share of Medicaid false claims act recoveries. Currently, if a state obtains a recovery from a state action relating to false or fraudulent Medicaid claims, the state must proportionally share the recovery with the federal government, according to the federal government's share in the cost of the state's Medicaid program. For example, if the state's Medicaid share is 40 percent, the state would be entitled to 40 percent of the recovery from an individual or entity that defrauded Medicaid—with the federal government entitled to the remaining 60 percent.

The Act's financial incentive for states is a decreased Federal Medical Assistance Percentage ("FMAP") for any amounts recovered pursuant to a state false claims action that was brought under a "qualifying" law.⁶ While Section 1909 does not require a state to enact false claims act legislation, only states that have enacted a qualifying law will be eligible for the 10-percentage-point increase in its share of Medicaid false claims recoveries. For example, if a state has a qualifying state false claims act and a Medicaid share of 50 percent, the state would be entitled to 60 percent of the recovery—with the federal government being entitled to the remaining 40 percent.

Section 1909(b) of the Act articulates the requirements that a state false claims law must include in order to qualify for the FMAP incentive:

1. The state law establishes liability to the state for false or fraudulent claims as described in the FCA with respect to any expenditures related to the state's Medicaid plan;
2. The state law contains provisions that are at least as effective in rewarding and facilitating *qui tam* actions as those in the FCA;
3. The state law contains a requirement for filing an action under seal for 60 days with review by the state's Attorney General; and
4. The state law contains a CMP that is not less than the CMP authorized by the FCA.

A state will not qualify for the 10-percentage-point increase in its share of recovery until after the Inspector General, in consultation with the U.S. Attorney General, has determined that the state law satisfies the foregoing requirements—the 10-percentage-point increase does not apply retroactively.⁷

Key Differences between the 2006 and 2013 Guidelines

The 2006 Guidelines tracked the then-current provisions of the FCA. The 2013 Guidelines account for key amendments to the FCA enacted in 2009 and 2010 by way of the Fraud Enforcement and Recovery Act of 2009 ("FERA"), the Patient Protection and Affordable Care Act ("PPACA"), and the Dodd-Frank Wall Street Reform and Consumer Protection Act ("Dodd-Frank Act").⁸ The 2013 Guidelines clarify that OIG will analyze Section 1909 compliance against the amended FCA.⁹

⁶ Medicaid funding is based on the FMAP, a formula inversely proportionate to state per capita income for a particular year, whereby the federal government will match a certain percentage of a state's Medicaid expenditures. The FMAP formula provides a matching amount of at least 50 percent and up to 83 percent of the state's Medicaid expenditures. See GUIDELINES, at 2.

⁷ *Id.* at 4.

⁸ *Id.* at 5.

⁹ *Id.*

1. Liability for False or Fraudulent Claims

Section 1909(b)(1) of the Act requires state law to establish liability for false or fraudulent claims described in the FCA with respect to any expenditures related to the state's Medicaid plan. The FCA, as amended by FERA, establishes liability for, among other things:

- knowingly presenting, or causing to be presented, a false or fraudulent claim for payment or approval (removing the prior requirement that the claim must be presented to an officer or employee of the government);
- knowingly making, using, or causing to be made or used, a false record or statement material to a false or fraudulent claim;
- conspiring to commit a violation of the FCA; and
- knowingly making, using, or causing 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 concealing or knowingly and improperly avoiding or decreasing an obligation to pay or transmit money or property to the government.¹⁰

FERA also amended the FCA by adding an expanded definition of “claim” and definitions for “obligations” and “material.”¹¹ To pass muster under Section 1909(b)(1) of the Act, state false claims statutes must establish liability for the same scope of conduct as provided in the amended FCA.

FERA expanded the FCA to impose liability for retention of overpayments. A party that knowingly conceals or fails to make a timely repayment of any “obligation to pay or transmit money or property to the government” may be liable for a false claim even in the absence of a false statement—known as a “reverse false claim.”¹² PPACA requires reporting and returning Medicare or Medicaid overpayments within 60 days from the date when the overpayment was identified or by the date when the corresponding cost report (if any) is due—whichever is later.¹³ Compliance risks for Medicare and Medicaid participants are amplified since the PPACA does not specify when an overpayment is “identified” for purposes of triggering the 60-day overpayment return period. Because false claims liability for retention of government overpayments is highly fact-specific, providers are advised to carefully assess compliance programs and risk tolerance when developing procedures for identifying, reporting, and refunding government overpayments.

2. Rewarding and Facilitating *Qui Tam* Actions

Section 1909(b)(2) of the Act requires state law to contain provisions that are at least as effective in rewarding and facilitating *qui tam* actions for false and fraudulent claims as those described in the FCA. OIG has made clear that onerous or restrictive state restrictions are grounds for determining that a state

¹⁰ See 31 U.S.C. § 3729(a).

¹¹ See 31 U.S.C. § 3729(b).

¹² 31 U.S.C. § 3729(a)(1)(G). Under Section 3729(a)(1)(G) of the FCA, a “reverse false claim” occurs when the payee of a federally sponsored program discovers the receipt of a payment to which it was not entitled and fails to return the overpayment. Prior to FERA, liability under this section had to be predicated on the payee’s affirmative use of false statements or records to retain or conceal the government payments. As amended, a payee’s mere passive retention of a known overpayment constitutes a violation.

¹³ 26 U.S.C. § 6402.

law is not as effective in rewarding and facilitating *qui tam* actions.¹⁴ Such provisions may include overly broad limitations on relators' rights, overly broad restrictions on relators' share of proceeds, overly onerous requirements placed on the relator, overly broad requirements for the relator to pay defendant's attorneys' fees, and overly broad jurisdictional bars.¹⁵

FERA and the Dodd-Frank Act amended the FCA to provide certain relief to any employee, contractor, or agent who is retaliated against because of lawful acts done in furtherance of a FCA action or efforts to stop FCA violations (with a three-year statute of limitations).¹⁶ State statutes should afford these individuals similar protections from retaliatory action in order to be approved by OIG.

Moreover, FERA amended the FCA to provide that, for statute of limitations purposes, any government pleading (whether filed separately or as an amendment to the relator's complaint) will relate back to the date that the relator's complaint was filed.

PPACA amended the FCA to provide that courts will dismiss a FCA action or claim, unless opposed by the government, if substantially the same allegations or transactions that were alleged in the action or claim were publicly disclosed: (1) in a federal criminal, civil, or administrative hearing in which the government (or its agent) is a party; (2) in a congressional, Government Accountability Office, or other federal report, hearing, audit, or investigation; or (3) by the news media, unless the action is brought by the Attorney General or the person bringing the action is an original source of the information.¹⁷ A state statute requiring courts to dismiss a broader category of cases based on a public disclosure, or not allowing a matter to proceed, in spite of the disclosure, unless opposed by the state, may be grounds for OIG determining that the state statute is not at least as effective in rewarding and facilitating *qui tam* actions.

Finally, PPACA amended the FCA to define "original source" as an individual who either: (1) prior to a public disclosure, voluntarily disclosed to the government the information on which the allegations or transactions in a claim are based; or (2) has knowledge that is independent of and materially adds to the publicly disclosed allegations or transactions, and who has voluntarily provided the information to the government before filing an action.¹⁸ A state statute with a more restrictive definition of "original source" may be grounds for OIG determining that the state statute is not at least as effective in rewarding and facilitating *qui tam* actions.

3. Civil Penalty Provisions

The FCA, as amended by FERA, now expressly provides that its civil penalty will be adjusted by the Federal Civil Penalties Inflation Adjustment Act of 1990.¹⁹ Section 1909(b)(4) of the Act requires state law to contain a CMP that is not less than the CMP authorized by the FCA. Pursuant to the Federal Civil Penalties Inflation Adjustment Act, a civil penalty under the FCA is not less than \$5,500 and not more than \$11,000 (formerly \$5,000–\$10,000). In order to qualify, state statutes need to include similar recoveries.

¹⁴ See U.S. Dep't of Health & Human Servs., Office of Inspector General, STATE FALSE CLAIMS ACT REVIEWS, *available at* <https://oig.hhs.gov/fraud/state-false-claims-act-reviews/index.asp> (containing formal reviews of 28 states' false claims laws for compliance with Section 1909 of the Act).

¹⁵ See GUIDELINES, at 10.

¹⁶ See 31 U.S.C. § 3730(h).

¹⁷ See 31 U.S.C. § 3730(e)(4)(A).

¹⁸ See 31 U.S.C. § 3730(e)(4)(B).

¹⁹ See 31 U.S.C. § 3729(a).

OIG Procedures for Reviewing State False Claims Acts

OIG will accept both enacted state laws for formal review and draft legislation for informal review and discussion.²⁰ State false claims acts that previously have been approved will be considered compliant until March 31, 2013. After that date, a previously approved state false claims act will no longer qualify for the Section 1909 incentive unless it has been: (1) amended and resubmitted to OIG, and (2) either approved by OIG or pending review by OIG.²¹ OIG anticipates granting two-year grace periods for approved state laws if any FCA provision relevant to OIG's review is amended in the future.²²

Consequences for Medicaid Providers and Key Takeaways

Unquestionably, these recent changes have expanded provider liability under the FCA, making it easier for relators to bring cases against health care providers, who may now be facing a more rigid regulatory regime. This recognition, coupled with a financial incentive, may spur state efforts to re-tool false claims statutes to comply with Section 1909 of the Act. Especially in the current economic climate where states are facing onerous budgetary pressures with respect to government programs like Medicaid, the potential for more lucrative recoveries may prompt those states that have not yet acted to pass false claims act legislation to do so in earnest. Even if the federal government declines to intervene in a case, the potential for increased damages may entice states to independently pursue false claims cases that may have otherwise gone untried.

States attempting to qualify for the financial incentive likely will enact or modify false claims legislation as needed to substantially comply with the FCA provisions. Attendant with increased interest in Medicaid false claims actions will inevitably come increased compliance scrutiny. Accordingly, assessing compliance programs to ensure conformity with state payor programs is advised.

For more information about this issue of *IMPLEMENTING HEALTH AND INSURANCE REFORM*, please contact one of the authors below or the member of the firm who normally handles your legal matters.

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²⁰ See GUIDELINES, at 1.

²¹ *Id.* at 5.

²² *Id.*

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