

THE FALSE CLAIMS ACT: RECENT CHANGES AFFECTING HEALTH CARE ENTITIES

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The False Claims Act (“FCA”), 31 U.S.C. § 3729 et seq., was enacted in 1863 during the presidency of Abraham Lincoln. The FCA, also known as the Lincoln Law, was established to prevent pricing fraud by persons and companies selling supplies to the Union Army during the Civil War. The original FCA contained a *qui tam* provision that allowed citizens, on behalf of the United States, to sue companies or individuals for false or fraudulent billings submitted to the government. The current version of the FCA still allows for *qui tam* actions for false or fraudulent claims.

While the FCA applies to any false claim submitted to the United States government, the FCA has been actively used as a tool for combating Medicare and Medicaid billing fraud. The Centers for Medicare and Medicaid Services (“CMS”) reports that Medicare and Medicaid spending was over \$500 billion for the 2006 fiscal year. In CMS’ 2006 *Management’s Discussion and Analysis*, administrators at CMS recognized that the best way to cut Medicare and Medicaid spending and maintain the integrity of the programs was to reduce Medicare and Medicaid fraud and abuse. For example, the Department of Health and Human Services reports that it collected almost \$2.3 billion in 2006 from false claims suits. By implementing and actively enforcing anti-fraud compliance laws, the government can recover more money and, thus, curb the amount of Medicare and Medicaid spending.

In order to further combat health care fraud and abuse, Congress enacted the Deficit Reduction Act of 2005 (“DRA”), P.L. 109-171. The DRA contains provisions to slow mandatory spending in Medicare and Medicaid. Furthermore, the DRA includes a provision, § 6032, that requires health care entities to address fraud and false claims within the Medicaid system. Section 6032, entitled “Employee Education About False Claims Recovery,” requires entities receiving or

making payments of more than \$5 million annually in Medicaid reimbursement to establish policies and disseminate information to employees about the False Claims Act and anti-fraud compliance. Notably, the DRA does not contain a similar provision requiring entities to address fraud within the Medicare system.

On December 13, 2006, CMS issued a letter to provide guidance to state Medicaid programs and health care entities on compliance with § 6032. According to CMS, § 6032 applies to any health care entity making or receiving \$5 million in Medicare payments, regardless of whether the entity is for-profit or not-for-profit, whether the payments are made at a single location or multiple locations, or whether the payments are made under multiple tax identification numbers. Entities subject to § 6032 must establish policies for all employees, including management, contractors, and agents, regarding false claims and fraud and abuse. Those policies must include detailed information about the federal FCA and any applicable state FCA, as well as the entity's policies for detecting fraud, waste, and abuse. The entity must also provide information to employees regarding the right of an employee to be protected as a whistleblower in a *qui tam* action.

According to § 6032, the entity must include this information in its employee handbook. CMS indicates that an entity that does not have an employee handbook is under no obligation to create one. However, CMS does indicate that it is the entity's responsibility to disseminate the written policies.

All health care entities subject to § 6032 were required to comply with the provisions of § 6032 by January 1, 2007. The penalty for non-compliance is high—health care providers can be excluded from participation in the Medicaid program. In addition, failure to establish and distribute false claims policies could result in false claims exposure. Furthermore, if a false claim

action is brought against an entity and the entity is found liable, the entity may have to pay treble damages to the government.

Currently, West Virginia does not have a false claims act governing all governmental transactions. However, West Virginia does have a statute that regulates fraud and abuse in the Medicaid program, West Virginia Code § 9-7-1 et seq. Section 9-7-1 indicates that the purpose of West Virginia's fraud and abuse statute is to combat the substantial sums of money that have been lost by the state and federal government in operation of the state's Medicaid program.

West Virginia's fraud and abuse statute states that "[a] person shall not make or present or cause to be made or presented to the [Department of Health and Human Resources] a claim under the medical programs of the department of welfare knowing the claim to be false, fraudulent or fictitious." W. Va. Code § 9-7-5(b) (1981). The statute provides for both civil and criminal penalties. In addition, any person or entity that violates the statute is liable to the Department of Health and Human Resources for fines equal to threetimes the amount of any payments received from which that person or entity was not entitled. W. Va. Code § 9-7-6 (1981).

If history is any indication, West Virginia also may enact false claims provisions that mimic the federal law. The DRA provides an incentive to states that establish false claims statutes. Under the incentive, states with false claims statutes will receive an additional 10% of any funds recovered under that statute. Because of this incentive, it is likely that West Virginia will update its fraud and abuse statute.

In the future, it is likely that all entities, whether receiving more or less than \$5 million in Medicaid payments, will be required to comply with § 6032's false claims and anti-fraud policies. Additionally, if § 6032 helps curtail Medicaid spending, fraud, and abuse, it is plausible that Congress will enact similar policies for the Medicare program. Due to the DRA's employee

education requirements and state incentive to create false claims acts, the future holds a strong likelihood of increased false claims investigation and litigation.

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