

2015

Mission - Combat Fraud: A Survey of State Mirror False Claims Acts to Prosecute Fraud and Abuse Surrounding the Medicaid Program

Alexa Salcito

Follow this and additional works at: https://scholarship.shu.edu/student_scholarship



Part of the [Law Commons](#)

Recommended Citation

Salcito, Alexa, "Mission - Combat Fraud: A Survey of State Mirror False Claims Acts to Prosecute Fraud and Abuse Surrounding the Medicaid Program" (2015). *Law School Student Scholarship*. 671.

https://scholarship.shu.edu/student_scholarship/671

MISSION - COMBAT FRAUD: A SURVEY OF STATE MIRROR FALSE CLAIMS ACTS TO
PROSECUTE FRAUD AND ABUSE SURROUNDING THE MEDICAID PROGRAM

By Alexa Salcito

INTRODUCTION:

The settlement amount 2.2 billion dollars, is one of the largest health care fraud settlements in U.S. History.¹ In November 2013, global health care giant Johnson & Johnson, paid this amount to resolve the civil and criminal allegations centered around its illegal off label promotion, and kickbacks, and False Claims Act violations.² "This multibillion-dollar resolution demonstrates the Justice Department's firm commitment to preventing and combating all forms of health care fraud," stated Attorney General Eric Holder when describing the impact of this resolution.³ This recovery is second to GlaxoSmithKline LLC which plead guilty to pay a total of approximately 3 billion dollars to settle civil and criminal allegations.⁴ Under the False Claims Act the company paid 2 billion dollars to the federal government and the states for claims involving the promotion of certain prescription drugs off-label, failure to report the drug's safety, and falsely reported drug prices.⁵

While the fight against Medicare fraud has been at full throttle for some time, the focus on Medicaid financial fraud is continuously evolving. One word previously has been used to

¹ Press Release, Office of Pub. Affairs U.S. Dep't of Justice, *Johnson & Johnson to Pay More Than \$2.2 Billion to Resolve Criminal and Civil Investigations* (Nov. 2, 2012) available at <http://www.justice.gov/opa/pr/2013/November/13-ag-1170.html>.

² *Id.*

³ *Id.*

⁴ Press Release, Office of Pub. Affairs U.S. Dep't of Justice, *GlaxoSmithKline to Plead Guilty and Pay \$3 Billion to Resolve Fraud Allegations and Failure to Report Safety Data* (July 2, 2012) available at <http://www.justice.gov/opa/pr/2012/July/12-civ-842.html>.

⁵ *Id.*

describe the governmental healthcare program of Medicaid, -- vulnerable.⁶ Beginning in 2010, the False Claims Act became the central vehicle used to prosecute Medicaid fraud.⁷ Medicaid is a state and federal program which covers an array of acute health care, long term care, and other services for over 62 million economically vulnerable Americans, or 1 in every 5 American citizens.⁸ The program comprises over 50 distinct state based programs whose expenditures are matched by the Federal government through a statutory formula based in part on each state's per capita income.⁹

While Medicaid has long covered pharmaceutical products, the relationship between the Pharmaceutical companies and Medicare is relatively new. The 2003 enactment of Medicare Part D, enabling seniors to enroll in private health plans that provide drug coverage, pharmaceutical companies reaped benefits from a whole new market.¹⁰ Historically drug coverage for seniors and the disabled was limited to the very poor who qualified for Medicaid, provided the states in which they lived included that benefit.¹¹ In 2005 nearly 6.5 million low income elderly individuals were transferred from Medicaid, which provided limited coverage at very low reimbursement rates, to Medicare Part D pursuant to which coverage the pharmaceutical companies negotiate drug prices with commercial insurers.¹² However, it is the

⁶ See U.S. Govt. Accountability Office, *HEALTH CARE FRAUD: Types of Providers Involved in Medicare, Medicaid, and the Children's Health Insurance Program Case* (Sept. 7, 2012) <http://www.gao.gov/products/GAO-12-820>

⁷ See *2010 Year-End False Claims Act Update*, GIBSON DUNN AND CRUTCHER LLP (Jan. 6, 2011) available at <http://www.gibsondunn.com/publications/pages/2010Year-EndFalseClaimsActUpdate.aspx>.

⁸ See *The Medicaid Program at a Glance*, THE HENRY J. KAISER FAMILY FOUNDATION (Mar. 4, 2013) available at <http://kff.org/medicaid/fact-sheet/the-medicaid-program-at-a-glance-update/>.

⁹ *High Risk Medicaid Program*, U.S. Government Accountability Office, http://www.gao.gov/highrisk/medicaid_program/why_did_study#t=0 (last visited Mar. 26, 2014).

¹⁰ Milt Freudenheim, *A Windfall From Shifts to Medicare*, N.Y. TIMES (July 18, 2006), <http://www.nytimes.com/2006/07/18/business/18place.html?pagewanted=all#>.

¹¹ *Id.*

¹² *Id.*

Medicaid federal program that determines the amount that will be paid for drugs based on a rebate program thus limiting the amount a company can charge Medicaid for a drug.¹³

In 2011, the Government Accountability Office estimated improper payments by Medicare and Medicaid were estimate at \$64.8 billion for that fiscal year alone.¹⁴ Fraud occurs when the pharmaceutical company may try to disguise or conceal the rebate payments.¹⁵ The companies must pay quarterly rebates to the Medicaid program, which are based on the company's drug sales that are then reported to the government.¹⁶ Each time a company dispenses drugs that are given to a Medicaid patient, they pay a rebate to Medicaid based on the average manufacturer's price or the best price, also understood as the lowest price, as reported by the company.¹⁷ Therefore, companies can inflate the price of the drug and conceal any discounts offered.¹⁸ This system allows the company to avoid reporting the rebates to Medicaid to match the discounted price they are providing to private insurers, wholesalers, pharmacists and businesses thus inflating the claim for reimbursement.¹⁹ Such a scheme is in violation of the False Claims Act.²⁰

Such shocking statistics inform a perception of pervasive systemic fraud that unsurprisingly feeds aggressive Congressional legislative and prosecutorial efforts under the FCA. This driving force has transformed the False Claims Act into one of the most powerful

¹³ Terry L. Leap, *Phantom Billing, Fake Prescriptions, and the High Cost of Medicine: Health Care Fraud and what to Do about it*, 118-119 (Cornell University Press, 2011).

¹⁴ *Id.*

¹⁵ *Id.*

¹⁶ George B. Moseley III, *Managing Legal Compliance in the Healthcare Industry*, 13 (Jones & Bartlett Publishers, 2013).

¹⁷ *Id.*

¹⁸ *Id.*

¹⁹ *Pharmaceutical Fraud*, PIETRAGALLO GORDON ALFANO BOSICK & RASPANTI, LLP, <http://www.falseclaimsact.com/common-types-of-fraud/pharmaceutical-fraud> (last visited, Mar. 27, 2014).

²⁰ Moseley III, *supra* note 10, at 13,

tools in the fight against Medicare and Medicaid financial fraud.²¹ Since January 2009, the Justice Department has recovered a staggering total of approximately 16.7 billion through False Claims Act cases.²² More than \$11.9 billion of that amount was recovered in cases involving fraud against federal health care programs.²³ Multiple organizations report that in mid 2012, three and a half years since the beginning of 2009, the federal government has concluded almost as many settlements and recovered more in financial penalties (49 settlements, totaling \$14.5 billion, respectively) as it has in the previous 18 years combined (55 settlements, totaling \$11.3 billion).²⁴

Pleased with the billions of dollars collected through aggressive use of the FCA, Congress enacted a bill incentivizing states to pass their own mini-False Claims Acts that meet certain criteria.²⁵ This has resulted in 30 states enacting "mirror" False Claims Statutes, ten of which have been approved by the HHS Office of Inspector General in 2013.²⁶ The opportunity to recover massive Medicaid dollars and fines has led States to enact legislation at a frantic pace in order to meet the federal government conditions and collect more lucrative settlement funds while expanding on their own ability to prosecute "fraud against the government."²⁷

This Note addresses State enactment of mirror state False Claims Acts, highlighting how single-state settlements amounts reclaimed through a state's False Claims Act is an imperative

²¹ Press Release, Office of Pub. Affairs U.S. Dep't of Justice, *Johnson & Johnson to Pay More Than \$2.2 Billion to Resolve Criminal and Civil Investigations* (Nov. 2, 2013) available at <http://www.justice.gov/opa/pr/2013/November/13-ag-1170.html>.

²² *Id.*

²³ *Id.*

²⁴ Sammy Almashat M.D. & Sidney Wolfe, M.D., *Pharmaceutical Industry Criminal and Civil Penalties: An Update*, PUBLIC CITIZEN (Sept. 27, 2012) available at <http://www.citizen.org/documents/2073.pdf>.

²⁵ *Id.*

²⁶ *Id.*; Notably, the Department of Justice can also recover Medicaid monies independently under the federal False Claims Act. Further, states have a longer history of Medicaid recoveries, focusing primarily on pricing schemes, because of the many states' drug coverage programs which pre-dated Medicare drug coverage.

²⁷ See *2013 Mid-Year False Claims Act Update*, GIBSON DUNN & CRUTCHER LLP (Jul. 10 2013,) available at <http://www.gibsondunn.com/publications/pages/2013-mid-year-false-claims-act-update.aspx>.

and effective mechanism to recover monies lost to fraud for their Medicaid programs. Part I of this Note concentrates on the statutory language of the False Claims Act and the provisions with which a State must comply to receive federal funding. Part II discusses the federal incentive that Congress created in the Deficit Reduction Act of 2005 and how states can draft their FCAs to comply with the DRA guidelines. Part III provides a survey chart that will demonstrate the increase that has occurred in State settlements. Part IV will analyze the rapid growth of Medicaid enrollees coupled with the looming Medicaid expansion under the Affordable Care Act and argue that States must employ vigorous enforcement of a mirror False Claims Act in order to combat the inevitable assault on the integrity of the federal health care program. This note concludes that state False Claims Acts are successful tools that allow states to increase their share of recovery of Medicaid dollars lost to fraud and abuse.

I. THE FEDERAL FALSE CLAIMS ACT

A. A Brief History of the Federal Statute

The False Claims Act originated on March 2, 1863, during the Civil War.²⁸ Also known at the time as Lincoln's Law, the Statute prosecuted "various frauds against the government including making or presenting false claims, false vouchers, false oaths, forged signatures, theft, embezzlement, and conspiracy."²⁹ These proscriptions applied to both military personnel and civilians.³⁰ The False Claims Act provided that "any person who knowingly submitted false claims to the government was liable for double the government's damages plus a penalty of

²⁸ CHARLES DOYLE, CONG. RESEARCH SERV., R40785, QUI TAM: THE FALSE CLAIMS ACT AND RELATED FEDERAL STATUTES 5 (2009).

²⁹ See CHARLES DOYLE, CONG. RESEARCH SERV., R40785, QUI TAM: THE FALSE CLAIMS ACT AND RELATED FEDERAL STATUTES 5 (2009), *citing* Section 1, Act of March 2, 1863, 12 Stat. at 696-97 (1863).

³⁰ CHARLES DOYLE, CONG. RESEARCH SERV., R40785, QUI TAM: THE FALSE CLAIMS ACT AND RELATED FEDERAL STATUTES 5 (2009).

\$2,000 for each false claim."³¹ Since its inception in 1863, the False Claims Act has been amended several times.³² The False Claims Act, 31 U.S.C. § 3729 et seq., now provides liability for triple damages and a penalty from \$5,500 to \$11,000 per claim for anyone who knowingly submits or causes the submission of a false or fraudulent claim to the United States.³³ The statute includes a unique legal device called a *qui tam* provision (from a Latin phrase meaning “he who brings a case on behalf of our lord the King, as well as for himself”).³⁴ This provision allows a private individual, known as a “relator,” to bring a lawsuit on behalf of the United States, where “the private person has information that the named defendant has knowingly submitted or caused the submission of false or fraudulent claims to the United States.”³⁵ The relator has the ability to bring a suit despite that they have not been personally harmed by the defendant’s conduct.³⁶

Since the birth of the False Claims Act during the Civil War, its purpose and basic premise of liability have remained virtually unchanged. The Act was created as a pro-active tool; intended to reach all types of fraud, without qualification, that might result in financial loss to the Government.”³⁷ In 1986, Congress substantially revised the False Claims Act “to strengthen and clarify the government's ability to detect and prosecute civil fraud and to recoup damages suffered by the government as a result of such fraud.”³⁸

³¹ *The False Claims Act: A Primer*, Civil Division, U.S. Department of Justice, available at http://www.justice.gov/civil/docs_forms/C-FRAUDS_FCA_Primer.pdf (last visited Oct. 17, 2013).

³² *Id.*

³³ *Id.*

³⁴ *Id.*

³⁵ *Id.*

³⁶ *The False Claims Act: A Primer*, Civil Division, U.S. Department of Justice, available at http://www.justice.gov/civil/docs_forms/C-FRAUDS_FCA_Primer.pdf (last visited Oct. 17, 2013)

³⁷ *United States v. Neifert-White Co.*, 390 U.S. 228, 233, (1968).

³⁸ *See* H.R. Rep. No. 99-660, at 16 (1986).

B. The Liability Standard:

The primary source of liability under the FCA, 31 U.S.C. § 3729 is contained in (a)(1)(A).³⁹ This provision states that "any person who, knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval, can be held liable for fraud under the False Claims Act."⁴⁰ Subparagraph (B) imposes liability on: [any person who] knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim.⁴¹ The principal distinction between (A) and (B) is that the latter requires the existence of a statement or record.⁴² Subparagraph (C) addresses concerted efforts to violate the Act. The provision imposes liability on: [any person who] conspires to commit a violation of subparagraph (A), (B), (D), (E), (F), or (G).⁴³ "The 2009 Amendments expanded the False Claims Act scope and extended its reach. Prior to the amendments, conspiracy liability was strictly limited to the submission of false claims.⁴⁴ Now liability extends to any type of conspiracy that would violate any other prohibitions under the FCA, including making false statements or retaining an overpayment given by the government."⁴⁵

The last subparagraph, (G), is the only provision that was not part of the original Act, which now prohibits "knowingly concealing or knowingly and improperly avoiding an obligation to the United States."⁴⁶ Congress added this new liability provision in 1986 which imposes

³⁹ 31 U.S.C.A. § 3729(a)(1)(A).

⁴⁰ *Id.*

⁴¹ 31 U.S.C.A. § 3729(a)(1)(B).

⁴² Claire M. Sylvia, *The False Claims Act: Fraud Against the Government*, § 4.1, West 2010 and Supp. 2012; *See, e.g.*, U.S. ex rel. Aakhus v. Dyncorp, Inc., 136 F.3d 676, 682-83, (10th Cir. 1998) (upholding district court's dismissal of a claim under former subsection (a)(2), now (a)(1)(B), where there was no evidence in the record on appeal of any representation or statement made by defendants).

⁴³ Claire M. Sylvia, *The False Claims Act: Fraud Against the Government*, § 4.4, West 2010 and Supp. 2012

⁴⁴ *See Federal False Claims Act Amended to Significantly Expand Liability*, Bryan Cave Bulletin, White Collar Defense and Investigations Client Service Group (May 27, 2009) available at <http://www.bryancave.com/files/Publication/549806d1-72e4-40a5-97f4-a1e20f4e4fd8/Presentation/PublicationAttachment/919b0799-6de4-49c8-b9df-08a7fa4fd302/White%20Collar%20Bulletin5-27-09.pdf>.

⁴⁵ *Id.*

⁴⁶ Claire M. Sylvia, *The False Claims Act: Fraud Against the Government*, § 4.1, West 2010 and Supp. 2012

liability for reverse false claims.⁴⁷ Subparagraph (G) imposes liability on: [any person who] knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government.⁴⁸ In order to establish a violation under this section the plaintiff must show that the defendant: "(1) knowingly; (2) made, used, or caused to be made or used, a false record or statement; (3) that is material to; (4) an obligation to pay or transmit money or property to the Government."⁴⁹ This is perhaps the section which allows for the greatest expansion of liability for Medicare or Medicaid payments.⁵⁰ A party may now be liable for retaining overpayments and for presenting false claims for payment approval.⁵¹

C. The Scierer Requirement - Knowingly:

Prior to 1986, the False Claims Act did not define the term "knowingly" and the Circuit Courts were split in their interpretation.⁵² A number of the Circuit Courts have construed the False Claims Act language to require "actual knowledge" of the fraud or a specific intent to defraud.⁵³ At the center of Congress's decision to amend the False Claims Act in 1986, was the need for a uniform standard of intent.⁵⁴ A standard, which was too stringent, would be inappropriate for a civil remedy which was designed to make the government whole for its losses.⁵⁵ Congress also feared that imposing a stringent standard would render the Government "unable to hold responsible those corporate officers who insulate themselves from knowledge of

⁴⁷ Claire M. Sylvia, *The False Claims Act: Fraud Against the Government*, § 4.12, West 2010 and Supp. 2012.

⁴⁸ 31 U.S.C.A. § 3729(a)(1)(G).

⁴⁹ *Id.*

⁵⁰ See Robert T. Rhoad & Matthew T. Fornataro, *A Gathering Storm: The New False Claims Act Amendments and Their Impact On Healthcare Fraud Enforcement*, 21 *The Health Lawyer* 14, 15-17 (discussing the FERA Amendments expansion of False Claims Act liability).

⁵¹ *Id.*

⁵² See, e.g., *U.S. v. Ekelman & Associates, Inc.*, 532 F.2d 545, 548, (6th Cir. 1976); *U.S. v. Aerodex, Inc.*, 469 F.2d 1003 (5th Cir. 1972); *U.S. v. Mead*, 426 F.2d 118 (9th Cir. 1970).

⁵³ *Id.*

⁵⁴ S. Rep. No. 99-345, at 6 to 7 (1986), reprinted in 1986 U.S.C.C.A.N. 5266, 5271 to 72 (and in Appendix B- 2).

⁵⁵ *Id.* at 7.

false claims submitted by lower-level subordinates."⁵⁶ Therefore, remedial actions along with a uniform standard of intent, were needed in order to combat the ‘ostrich-like’ conduct which can occur in large corporations.⁵⁷

The False Claims Act now includes a definition of "Knowing." Section 3729(b) defines the term “knowingly” to mean that a party: "(1) has actual knowledge of the truth or falsity information; (2) acts in deliberate ignorance of the truth or falsity of the information; or (3) acts in reckless disregard of the truth or falsity of the information."⁵⁸ The Act provides that no proof of specific intent is required.⁵⁹ Prior to these amendments, a defendant could escape liability by demonstrating that, although the claims were erroneous (i.e., false), the defendant did not consciously intend to cheat the government.⁶⁰ Thus, claims submitted in a careless, unsupervised fashion did not constitute false claims.⁶¹ It was also unclear whether persons would be liable if they were confronted with potential “red flags,” or were alerted to the issue and avoided obtaining additional information that would reveal whether the claim was in fact truthful.⁶² Congress sought to capture both types of cases within the scope of the FCA when it added, as part of its 1986 amendments, a definition of “knowledge” that included acts done in reckless, disregard, or deliberate ignorance. The 2009 amendments eliminated the reference to “defraud,” and now refer only to a conspiracy to violate the other provisions of the Act.⁶³ Congress wanted

⁵⁶ *Id.*

⁵⁷ *Id.*

⁵⁸ 31 U.S.C.A. § 3729(b).

⁵⁹ *Id.*

⁶⁰ *See, e.g.,* United States v. Davis, 809 F.2d 1509 (11th Cir. 1987); United States v. Mead, 426 F.2d 118 (9th Cir. 1970).

⁶¹ *See, e.g.,* 132 Cong. Rec. 20, 535–36 (Aug. 11, 1986).

⁶² *See, e.g.,* S. Rep. No. 99-345, at 6–7, reprinted in 1986 U.S.C.C.A.N. 5271–72.

⁶³ Claire M. Sylvia, *The False Claims Act: Fraud Against the Government*, § 4.8, West 2010 and Supp. 2012.

to eliminate any questions, or differing interpretation about whether any different level of intent is required for a violation of this section.⁶⁴

D. The Qui Tam Provision:

The False Claims Act's *qui tam* provision allows a private citizen, called a relator, to sue on behalf of the government.⁶⁵ If the government elects to join the action then it is brought in the name of the United States.⁶⁶ If the government chooses not to assume primary responsibility for the litigation, it may intervene later in the proceedings upon a showing of cause.⁶⁷ The government also has the ability to move to dismiss, or settle the litigation over the objections of the relator, as long as the relator is given an opportunity to be heard.⁶⁸

The process for filing and pursuit of these cases is detailed.⁶⁹ The relator must be represented by an attorney who files the complaint under seal exclusively with the United States Department of Justice (DOJ), including the local United States Attorney, and to the assigned judge of the District Court.⁷⁰ While the statute provides that the complaint remains under seal for sixty days, the government generally obtains an extension, which can extend for years.⁷¹ The investigation of the allegations is generally conducted by HHS investigators whose findings may then be shared beyond Justice, to other enforcement agencies, such as the Office of the Inspector

⁶⁴ *Id.*

⁶⁵ 31 U.S.C.A. § 3730(b)(1) (2013).

⁶⁶ 31 U.S.C. § 3730(a). (2013).

⁶⁷ 31 U.S.C. § 3730(c)(3) (2013).

⁶⁸ 31 U.S.C. § 3730(c)(2)(A), (B). (2013).

⁶⁹ *FALSE CLAIMS ACT CASES: GOVERNMENT INTERVENTION IN QUI TAM (WHISTLEBLOWER)SUITS*, Civil Division, Department of Justice, available at http://www.justice.gov/usao/pae/Civil_Division/InternetWhistleblower%20update.pdf

⁷⁰ *Id.*; Under seal is the method used by which the Clerk of the Court keeps all records pertaining to the case on a secret docket.

⁷¹ *Id.*

General.⁷² In Medicaid cases, the practice followed is to allow relators who file in Federal District Court to file under both the Federal False Claims Act and if possible the state's False Claims Act.⁷³ Such a procedural mechanism allows the states to be represented and work simultaneously with the Federal government.⁷⁴

The DOJ must choose how to proceed with the case by selecting one of three options: (1) intervene in one or more counts of the pending qui tam action; (2) decline to intervene in one or all counts of the pending qui tam action; (3) move to dismiss the relator's complaint, either because there is no case, or the case conflicts with significant statutory or policy interests of the United States.⁷⁵ If the United States declines to intervene, the relator and his attorney may prosecute the action on behalf of the United States, but the United States is not a party to the proceedings apart from its right to any recovery.⁷⁶ If the DOJ does intervene then a notice of intervention is filed along with a motion to unseal the qui tam complaint filed by the relator and the notice of intervention.⁷⁷ Once the complaint is unsealed, the relator and their attorney have 120 days under the Rules of Federal Civil Procedure to serve the complaint on each named defendant.⁷⁸

II - THE BATTLE AGAINST FRAUD WAGES ON:

A. The Deficit Reduction Act of 2006:

⁷² *Id.*

⁷³ Telephone Interview with John Krayniak, Retired Asst. Att. General of New Jersey, (Mar. 27, 2014).

⁷⁴ *Id.*

⁷⁵ *FALSE CLAIMS ACT CASES: GOVERNMENT INTERVENTION IN QUI TAM (WHISTLEBLOWER) SUITS*, Civil Division, Department of Justice, *available at* http://www.justice.gov/usao/pae/Civil_Division/InternetWhistleblower%20update.pdf.

⁷⁶ *Id.*

⁷⁷ *Id.*

⁷⁸ *Id.*, *citing* Fed. R Civ. P. 4.

In fiscal year 2005, the federal government recovered approximately \$1.47 billion in settlements and judgments that involved health card fraud.⁷⁹ Congress, responding to a desire to replicate the success of the federal False Claims Act in the states, passed legislation to encourage states to establish state statutes modeled on the federal False Claims Act.⁸⁰ Section 6031 of the Deficit Reduction Act (DRA), entitled *Encouraging the Enactment of State False Claims Acts*, amends Title XIX of the Social Security Act by adding a new section, which provides a financial incentive for states to enact false claims laws that are comparable to the Federal False Claims Act, and establish liability to the State for those who submit false or fraudulent claims to the State's Medicaid program.⁸¹

"Sec. 1909. (a) In General.--Notwithstanding section 1905(b), if a State has in effect a law relating to false or fraudulent claims that meets the requirements of subsection (b), the Federal medical assistance percentage with respect to any amounts recovered under a State action brought under such law, shall be decreased by 10 percentage points."⁸²

In a statement released by Sen. Chuck Grassley, chairman of the Committee on Finance, the senator summarized the importance of the False Claims Act as a tool for fighting fraud, waste, and abuse.⁸³ He zealously advocated that the passage of the Deficit Reduction Act would enhance the False Claims Act's power, and increase its prosecutorial effort while remaining only a necessary tool to be used in fettering out those who seek to deceive the government.⁸⁴

⁷⁹ *The Department of Health and Human Services And The Department of Justice Health Care Fraud and Abuse Control Program Annual Report For FY 2005*, OFFICE OF INSPECTOR GENERAL, U.S. DEPARTMENT OF HEALTH & SHUMAN SERVICES (Aug. 2006) available at <https://oig.hhs.gov/publications/docs/hcfac/hcfacreport2005.pdf>.

⁸⁰ Kristen V. Mayver, John J. Reynolds, III, Joshua A. Cippel, *State False Claims Laws and Compliance With The DRA: What is Required After FERA and PPACA?*, ROPES & GRAY LLC, available at <http://www.ropesgray.com/~media/Files/articles/2010/05/mayer-reynolds-cippel-author-article-for-aba-national-institute-on-the-civil-false-claims-act-and-qui-tam-enforcement.pdf>.

⁸¹ 31 U.S.C. § 3729 (West) (2013).

⁸² Deficit Reduction Act of 2005, Pub. L. No. 109-171.

⁸³ Chuck Grassley, *False Claims Act Enhancements in Deficit Reduction Act of 2005*, VOTE SMART (Feb. 2, 2005) available at http://votesmart.org/public-statement/151363/false-claims-act-enhancements-in-deficit-reduction-act-of-2005#.UmKvM1A_u-E.

⁸⁴ *Id.*

Section 1909 of the Act, rewards states that enact a qualifying False Claims Act. This section provides a federal incentive for states to enact mirror False Claims Acts, which establish liability to the state for the submission of false and/or fraudulent claims to that State's Medicaid program.⁸⁵ The federal government will increase the state's share of Medicaid recoveries by 10 percent, thereby allowing the state to keep money that would otherwise have gone to the federal government.⁸⁶ In a state with a 50-50 percent federal Medicaid split, the DRA bonus would increase the Medicaid fund recovery to 60 percent that is awarded to the state.⁸⁷ In a False Claims Act claim of 20 million dollars that has been falsely submitted, the damage may be tripled to 60 million under § 3729 section (G).⁸⁸ The relator, a whistleblower who brought claim, is awarded a share averaged at 17 percent, therefore 10.2 million of 60 million is subtracted from the total.⁸⁹ The 49.8 million is then split, 40 percent to the federal government, and 60 percent to the state.⁹⁰ The state receives a significantly higher portion of money, 29.88 million dollars, and the government receives 19.92 million dollars.⁹¹

The state False Claims Act must satisfy four criteria to qualify for the federal increase of 10 percentage points to the Medicaid program: the law (1) establishes liability to the State for false or fraudulent claims described with respect to any expenditures described in the Medicaid

⁸⁵ *Practice Tool 18 Survey of State False Claims Statutes with Qui Tam Provisions* (Bloomberg Law Portfolio 2650: False Claims Act: Health Care Applications and Defense, Working Papers) available at <http://www.bloomberglaw.com/p/f90d8eac6ac34a9d780d0fee47e0b7c6/document/2760181288>.

⁸⁶ The Medicaid program is jointly funded by the government who pays the states for a percentage of program expenditures. This is called the Federal Medical Assistance Percentage (FMAP). The FMAP varies by state, with the average state FMAP at 57%, but this ranges from 50% in wealthier states up to 75% in states with lower per capita incomes.

⁸⁷ Jim Moorman & Roderick Chen, *How States Can Recover Stolen Money*, TAF ORG., available at http://www.taf.org/OIG_TAF_Presentation.ppt (last visited Mar. 26, 2014).

⁸⁸ 31 U.S.C.A. § 3729 (West) (2013).

⁸⁹ Jim Moorman & Roderick Chen, *How States Can Recover Stolen Money*, TAF ORG., available at http://www.taf.org/OIG_TAF_Presentation.ppt (last visited Mar. 26, 2014).

⁹⁰ *Id.*

⁹¹ *Id.*

program; (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 the Federal Act; (3) contains a requirement that whistleblowers are allowed to file actions with a 60 day review period by the Attorney General; and (4) contains a civil penalty that is not less than the amount of the civil penalty authorized by the Federal FCA.⁹² The Health and Human Services OIG must determine the state statute meets the requirements before the state is entitled to the enhanced recovery and it must be met within the specific deadline provided by the OIG.⁹³

B. Receiving the Federal Incentives - It's All About Compliance:

On August 21, 2006, the Office of Inspector General (OIG) announced the factors upon which the Inspector General would rely upon, when determining whether a State law qualifies for the federal incentives.⁹⁴ Congress amended the False Claims Act in 2009, which prevented it from becoming a boundless all purpose anti-fraud statute which would succumb to a constitutional challenge.⁹⁵ In March of 2011, the OIG re-evaluated states' False Claims Act statutes pursuant to the 2009 amendments, and concluded that no state complied with the DRA requirements.⁹⁶ The States received a two year grace period to amend their statutes, and resubmit for OIG approval.⁹⁷ States that had qualified for the financial incentive before the

⁹² Robert T. Rhoad, *False Claims Act Education Requirements Under the Deficit Reduction Act: Compliance Guidance for Health Care Organizations in the Wake of Uncertainty*, 19 *The Health Lawyer* 18, 19-20, (2007).

⁹³ *Id.*

⁹⁴ *Practice Tool 18 Survey of State False Claims Statutes with Qui Tam Provisions* (Bloomberg Law Portfolio 2650: False Claims Act: Health Care Applications and Defense, Working Papers) available at <http://www.bloomberglaw.com/p/f90d8eac6ac34a9d780d0fee47e0b7c6/document/2760181288>.

⁹⁵ See *Fraud Enforcement and Recovery Act*, Pub. L. No. 111-21, 123 Stat. 1616; citing *Allison Engine Co. v. United States ex rel. Sanders*, 128 S. Ct. 2123, 2130 (2008).

⁹⁶ *Practice Tool 18 Survey of State False Claims Statutes with Qui Tam Provisions* (Bloomberg Law Portfolio 2650: False Claims Act: Health Care Applications and Defense, Working Papers) available at <http://www.bloomberglaw.com/p/f90d8eac6ac34a9d780d0fee47e0b7c6/document/2760181288>.

⁹⁷ See *UPDATED OIG Guidelines for Evaluating State False Claims Acts*, Office of the Attorney General (March 15, 2013) available at <https://oig.hhs.gov/fraud/docs/falseclaimsact/guidelines-sfca.pdf>.

amendments were given a two year grace period to amend and resubmit.⁹⁸ These states continued to qualify until March 31, 2013.⁹⁹

This two year grace period was enacted to enable each State to amend their False Claims Act to meet the requirements for enhanced recovery.¹⁰⁰ For example California's statute did not provide "at least" a 3-year statute of limitations for retaliation actions.¹⁰¹ Therefore, the California False Claims Act was not at least as effective in rewarding and facilitating qui tam actions as the Federal False Claims Act.¹⁰² Louisiana's False Claims Act, which failed to pass OIG muster, set a recovery percentage which was too low for whistleblowers.¹⁰³ Florida's False Claims Act did not establish liability for the same breadth of conduct as the Federal False Claims Act; the Federal False Claims Act, as amended by the Fraud Enforcement and Recovery Act, includes an expanded definition of the term "claim" and defines the terms "obligation" and "material."¹⁰⁴ Michigan's False Claims Act omitted penalties and liability for decreasing or

⁹⁸ *Id.*

⁹⁹ See *2011 Mid-Year False Claims Act Update*, GIBSON DUNN & CRUTCHER LLP (Jul 14, 2011) available at <http://www.gibsondunn.com/publications/pages/2011Mid-YearFalseClaimsActUpdate.aspx>.

¹⁰⁰ *Id.*

¹⁰¹ Cal. Gov't Code § 12650 (West); Letter from Daniel R. Levinson, Inspector Gen., U.S. Dep't of Health & Human Servs. to Kamala D. Harris, Att'y Gen. of Cal. (Aug. 30, 2011), available at <http://oig.hhs.gov/fraud/docs/falseclaimsact/california-supplement.pdf>; The pre-FERA version of the FCA allowed retaliation claims for any employee who is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment by his or her employer because of lawful acts. FERA amended this in 2009 to a uniform statute that allows employees to bring a claim within 3 years after the date of when the retaliation occurred.

¹⁰² *Id.*

¹⁰³ La. Rev. Stat. Ann. §§ 46:439.4; Letter from Daniel R. Levinson, Inspector Gen., U.S. Dep't of Health & Human Servs. to Nicholas J. Diez, Ass. Att'y Gen. of LA. (Nov. 15, 2011), available at <http://oig.hhs.gov/fraud/docs/falseclaimsact/Louisiana.pdf>.

¹⁰⁴ Fla. Stat. § 68.081- 68.092; Letter from Daniel R. Levinson, Inspector Gen., U.S. Dep't of Health & Human Servs. to David Lewis, Dir. Medicaid Fraud Control Unity of FL. (Mar. 21, 2011), available at <http://oig.hhs.gov/fraud/docs/falseclaimsact/Florida.pdf>.

avoiding an obligation to pay the government, i.e., a “reverse false claim.”¹⁰⁵ After these reviews, many States laws are in flux, trying to amend and meet the DRA requirements.

C. Reinforcing Compliance:

In 2013, after consulting with the Department of Justice, the OIG released updated guidelines intended to highlight the False Claims Act provisions relevant to OIG’s determination of whether a state law meets the requirements.¹⁰⁶ Specifically, the updated guidelines provide that the state False Claims Act must define the terms “knowing,” and “knowingly” consistent with the federal statutory definition.¹⁰⁷ The terms “claim,” “obligation,” and “material” must also meet the specified definitions that are stated within the guidelines. Adherence to these specific terms is vital because it maintains that the state law fully establishes liability to the state for the fraudulent claim.¹⁰⁸

Qui Tam provisions received particular attention as many critics of the federal law, including some prosecutors, believe that relators' recovery is unjustifiably high.¹⁰⁹ In 2012, qui tam relators earned more than 439 million dollars in share awards. More than 60% of the government's recoveries in 2012, 3.3 billion dollars, derived from cases initiated under the False Claims Act's qui tam provisions, and whistleblowers initiated more new matters in 2012 than in

¹⁰⁵ Mich. Comp. Laws §§ 400.601 - 400.615; Letter from Daniel R. Levinson, Inspector Gen., U.S. Dep't of Health & Human Servs. to Mike Cox, Att'y Gen of MI. (Mar. 21, 2011), *available at* <http://oig.hhs.gov/fraud/docs/falseclaimsact/Michigan.pdf>

¹⁰⁶ See *UPDATED OIG Guidelines for Evaluating State False Claims Acts*, Office of the Attorney General (March 15, 2013) *available at* <https://oig.hhs.gov/fraud/docs/falseclaimsact/guidelines-sfca.pdf>.

¹⁰⁷ See *UPDATED OIG Guidelines for Evaluating State False Claims Acts*, Office of the Attorney General (March 15, 2013) *available at* <https://oig.hhs.gov/fraud/docs/falseclaimsact/guidelines-sfca.pdf>.

¹⁰⁸ *Id.*

¹⁰⁹ See Press Release, Office of Pub. Affairs U.S. Dep't of Justice, *Justice Department Recovers Nearly \$5 Billion in False Claims Act Cases in Fiscal Year 2012* (Dec. 4, 2012) *available at* <http://www.justice.gov/opa/pr/2012/December/12-ag-1439.html>.

any prior year on record.¹¹⁰ Thus many states scaled back relator recovery in their statutes.¹¹¹ The OIG rejects this, a State may not set provisions that are more restrictive than those found in the Federal FCA when determining facilitations and rewards for successful relators.¹¹² In the 2013 guidelines, the OIG highlights that provisions which are overly onerous on the relator's ability to bring the claim, or provide an overly broad requirement on the relator's share of proceeds and paying defendant's attorney's fees, will be deemed as ineffective.¹¹³ Provisions that the OIG may consider also include any jurisdictional bar that is broader than that which has been established under the Federal FCA.¹¹⁴ Essentially the State FCA statutes must allow a relator to feel that they have an ability to bring a claim without incurring too high a burden.

The last two requirements for sections 1909(b)(3) and 1909(b)(4) are not open to as much interpretation as the previous two sections. Under 1909(b)(3) the State law must contain language that specifies the existence of a seal provision.¹¹⁵ "When evaluating whether a State law meets the requirements of section 1909(b)(3) of the Act, OIG will consider whether the law requires the complaint to be filed in camera and to remain under seal for at least 60 days."¹¹⁶ The final condition that a State FCA must contain is a civil penalty provision. The civil penalty cannot be less than the civil penalty amount authorized under 31 U.S.C. 3729.¹¹⁷ Two specific components of the damages required will be considered by the OIG: (1) at least treble damages

¹¹⁰ *Id.*

¹¹¹ *Id.*

¹¹² See 31 U.S.C. § 3730(c) (West) (2013).

¹¹³ See *UPDATED OIG Guidelines for Evaluating State False Claims Acts*, Office of the Attorney General (March 15, 2013) available at <https://oig.hhs.gov/fraud/docs/falseclaimsact/guidelines-sfca.pdf>.

¹¹⁴ *Id.*

¹¹⁵ *Id.*

¹¹⁶ *Id.*

¹¹⁷ See 31 U.S.C. § 3729(a)(1)(G) (West) (2013).

and (2) civil penalties of at least \$5,000 to \$10,000 as adjusted by the Federal Civil Penalties Inflation Adjustment Act of 1990.¹¹⁸

III. A STATE SURVEY: LEGISLATIVE ACTIVITY AT THE STATE LEVEL:

During the first six months of 2012 a flurry of state activity was taking place as states were struggling to keep up with the 2009 False Claims Act amendments. In 2009 Congress passed the Fraud Enforcement Recovery Act (FERA) which amended the False Claims Act for the first time in 20 years.¹¹⁹ FERA's objective was to strengthen the False Claims Act in several ways: (1) expanding potential liability for false claims by applying the FCA to more entities and a broader range of transactions (2) reducing the proof required to establish liability; (3) expanding the pool of potential whistleblowers that may bring retaliation claims.¹²⁰ After the highly lucrative \$3.03 billion recovered by the government in 2011, states began proactively legislating in an attempt to enact or expand their FCAs to meet the requirements so that they could mimic the government's increase in recovery settlements.¹²¹ Compilation of a survey chart depicts the increased amount of state False Claims settlements, recoveries, and evolving potential that the state False Claims Acts possess when used aggressively.¹²² However, it is important to understand and accept that timing always is an important factor. The renowned

¹¹⁸ See *UPDATED OIG Guidelines for Evaluating State False Claims Acts*, Office of the Attorney General (March 15, 2013) available at <https://oig.hhs.gov/fraud/docs/falseclaimsact/guidelines-sfca.pdf>.

¹¹⁹ *Id.*

¹²⁰ Fraud Enforcement and Recovery Act of 2009, Pub. L. No. 111-21, 123 Stat. 1617. (2009).

¹²¹ See *Fraud Statistics -- Overview*, U.S. Dep't of Justice (Dec. 7, 2011), available at http://www.justice.gov/civil/docs_forms/C-FRAUDS_FCA_Statistics.pdf; Press Release; See also U.S. Dep't of Justice, Office of Pub. Affairs, *Justice Department Recovers \$3 Billion in False Claims Act Cases in Fiscal Year 2011* (Dec. 19, 2011), available at <http://www.justice.gov/opa/pr/2011/December/11-civ-1665.html>.

¹²² The data and amounts presented in the chart were obtained through a search of each specific state's Press Releases located in their Attorney General website for the archived years of 2011 and 2012. The National State Medicaid Fraud Control Unit was contacted and explained that the agency does not keep records of the individual state False Claims Act settlements. Therefore the search was restricted to reviewing each state website, compiling the figures, and then adding the total settlements recorded for the state alone. Other settlement amounts do exist, however this survey only pertains to individual state settlement shares that were publicly available in press releases. This chart is an estimate based off of the available figures.

GlaxoSmithKline False Claims Act settlement occurred in 2012.¹²³ The results depicted in this chart underscore that the recoveries have increased dramatically, but it is crucial to understand that settlements occur at different times and rates therefore it is necessary that states either enact False Claims Act statutes and/or pursue the DRA incentive to increase the Medicaid recoveries.

State	Year State FCA was Passed	Date Deemed Compliant	Qui Tam Provision	DRA Compliant	2011 Settlement Amount	2012 Settlement Amount
Arkansas	1993	No determination has yet been made	Ark. Code Ann. § 20-77-911	N	\$150,693.73	\$14,457,683.50
California	1987	April 23, 2013	Cal. Gov't Code §§12652	Y	\$181,260,000 ¹²⁴	\$124,335,849
Colorado	2010	Oct. 24, 2013	C.R.S.A. § 25.5-4-306	Y	\$7,939,479	\$11,987,937
Connecticut	1997	Nov. 15, 2011	General	Y	\$8,108,039	\$22,768,253
Delaware	2000	Not deemed compliant as of 3/21/2011	Del. Code Ann. tit. 6, §§1205	N	None reported	
District of Columbia	1998	No determination made.	D.C. Code §§2-381.15	N	\$1,300,000	\$7,510,059
Florida	1994	Not deemed compliant as of 3/21/2011	Fla. Stat. §§68.085	N	\$53,771,000	\$139,500,000
Georgia	2007	Must be deemed	Ga. Code Ann. §§49-4-168.2	N	\$29,247,033.71	\$85,622,555.72

¹²³ See *supra* note 4.

¹²⁴ California's 2011 settlement total was higher because the state had its largest recovery in the history under its own state California False Claims Act.

		compliant by 8/31/2013				
Hawaii	2000	May 22, 2013	Haw. Rev. Stat. §§661-21- 27	Y	None reported	
Illinois	1992	May 22, 2013	740 Ill. Comp. Stat. 175/8	Y	\$19,950,000	\$62,100,000
Indiana	2005	Deemed not compliant as of 3/21/2011; Two year grace period given	General	N	\$3,428,000	\$19,135,000
Iowa	2010	Dec. 29, 2011	Iowa Code §§685.3	Y	\$2,416,570	\$6,337,123
Louisiana	1997	Nov. 15, 2011	La. Rev. Stat. Ann. §§46:439.2	Y	\$9,709,657.35	\$81,883,000
Massachusetts	2000	July 31, 2013	Mass. Gen. Laws ch. 12, §§5F	Y	43,200,000 ¹²⁵	\$62,330,000
Michigan	2008	Deemed not compliant as of 3/21/2011; Two year grace period given	Mich. Comp. Laws §§400.610a	N	\$4,120,187	None Reported
Minnesota	2010	Deemed not compliant as of 3/21/2011; Two year grace period given	General	N	None Reported	

¹²⁵ See Mass. Attorney General Press Release, *More Than \$40 Million Recovered Under False Claims Act by AG Coakley's Office in Fiscal Year 2011* (Feb. 12, 2012) available at <http://www.mass.gov/ago/news-and-updates/press-releases/2012/2012-02-16-false-claims-recoveries.html>(total amount was taken from this article due the differing final numbers from the press releases).

Montana	2005	Oct. 24, 2013.	Mont. Code Ann. §§17-8-410	Y	\$558,418	\$986,000
Nevada	1999	Deemed not compliant as of 8/31/2011; Two year grace period given	Nev. Rev. Stat. §§357.210	N	\$1,817,093	\$7,024,610
New Hampshire	2005	Deemed not compliant as of 7/24/2008	N.H. Rev. Stat. Ann. §§167:61-e	N	\$355,000	\$5,695,299.98
New Jersey	2008	Deemed not compliant as of 3/21/2011; Two year grace period given	N.J. Stat. Ann. §§2A:32C-7	N	\$3,800,000	\$29,611,181
New Mexico	2004	Deemed not compliant as of 7/24/2008	N.M. Stat. Ann. §§44-9-7	N	None reported	
New York	2007	Deemed not compliant as of 3/21/2011; Two year grace period given	N.Y. State Fin. Law §§190	N	\$73,850,000	\$171,051,305
North Carolina	2009	Deemed not compliant as of 3/21/2011; Two year grace period given	N.C. Gen. Stat. §§1-610	N	\$30,257,808.03	\$65,789,788.47
Oklahoma	2007	Not compliant with pre-amendment requirements 7/24/2008	Okla. Stat. tit. 63, §§5053.4	N	None reported	\$1,550,000

Rhode Island	2008	Oct. 24, 2013	R.I. Gen. Laws §§9-1.1-4	Y	\$1,640,814.81	\$2,745,000
Tennessee	2001	July 31, 2013	Tenn. Code Ann. §§71-5- 1813	Y	\$3,358,317	\$32,550,000
Texas	1995	Sept, 12, 2013	Tex. Hum. Res. Code Ann. §§36.110	Y	\$64,930,000	\$247,108,250
Virginia	2003	Deemed not compliant as of 3/21/2011; Two year grace period given	Va. Code. Ann. §§8.01-216.7	N	None Reported	\$14,800,000
Washington	2012	Nov. 20, 2011	Wash. Rev. Code §§74.66.070	Y	\$9,714,511	\$47,912,950
Wisconsin	2008	Not deemed compliant as of 3/21/2011	Wis. Stat. §20.931(11)(a)	N	\$8,739,312.36	\$34,468,508.84

PART VI: THE RETURN ON MEDICAID INVESTMENT UNDER STATE FALSE CLAIMS ACTS:

A. Medicaid Eligibility and Funding:

The year 2013 can be commemorated as a significant marker for the Medicaid program; the numbers revealed that this federal program now plays an integral role in our nation because it covers over 62 million Americans which is more than Medicare or any other private insurer.¹²⁶ Congress created Medicaid as a means tested entitlement program that has been in existence for

¹²⁶*Medicaid: A Primer Key Information on the Nation's Health Coverage Program for Low-Income People*, THE KAISER COMMISSION ON MEDICAID AND THE UNINSURED, 1 (March 2013) available at <http://kaiserfamilyfoundation.files.wordpress.com/2010/06/7334-05.pdf>.

over 35 years.¹²⁷ Historically, Medicaid eligibility was subject to specific categorical restrictions limited to the elderly, individuals with disabilities, pregnant women and children.¹²⁸ In addition, applicants' had to meet financial requirements which were determined on assessment of their resources and wages which could result in cash assistance.¹²⁹ However, in recent years Medicaid *has opted out of this cash assistance program* and has expanded to include a broad range of the low income population, including pregnant women, children and some parents in both working and jobless families, children and adults with diverse physical and mental health conditions and disabilities, and poor elderly and disabled Medicare beneficiaries including many long term needs.¹³⁰ Another subset has developed in which 1 in every 5 Medicare beneficiaries is also covered by Medicaid. These individuals are known as "dual eligible," and are usually in a severe state of poverty and in much worse health than other Medicare enrollees.¹³¹

Medicaid was passed by the U.S. House and Representatives, the Senate, and then signed into law by president Lyndon Johnsons in 1965.¹³² At its inception it was determined that such a major spending program would be a partnership allowing the federal and state governments to share the cost of Medicaid.¹³³ States, who have now elected to participate in Medicaid, are reimbursed by the federal government for a portion of their program costs.¹³⁴ The federal-state match is known as FMAP, federal Medicaid assistance program, which is calculated through a

¹²⁷ ELICIA HERZ ET AL, CONG. RESEARCH SERV., RL32277, *HOW MEDICAID WORKS: PROGRAM BASICS*, 1 (March 16, 2005).

¹²⁸ ELICIA HERZ, CONG. RESEARCH SERV., RL33202, *MEDICAID: A PRIMER*, 1 (July 18, 2012).

¹²⁹ *Id.*

¹³⁰ *Medicaid: A Primer Key Information on the Nation's Health Coverage Program for Low-Income People*, THE KAISER COMMISSION ON MEDICAID AND THE UNINSURED, 3 (March 2013) available at <http://kaiserfamilyfoundation.files.wordpress.com/2010/06/7334-05.pdf>.

¹³¹ *Id.* at 10.

¹³² *Medicaid: A Timeline of Key Developments*, THE KAISER COMMISSION ON MEDICAID AND THE UNINSURED (February 13, 2014) <http://kaiserfamilyfoundation.files.wordpress.com/2008/04/5-02-13-medicaid-timeline.pdf>.

¹³³ ELICIA HERZ ET AL, CONG. RESEARCH SERV., RL32277, *HOW MEDICAID WORKS: PROGRAM BASICS*, 1 (March 16, 2005).

¹³⁴ *Id.*

financial formula that is found in Sections 1905(b) and 1101(a)(8)(B) of the Social Security Act.¹³⁵ The FMAP varies from state to state with the poorer states usually receiving larger federal amounts for each Medicaid dollar expended.¹³⁶ Under the formula, the state's per capita income is computed and compared with the national per capita income.¹³⁷ If the state is equal to the national average per capita income then the federal share is 55 percent.¹³⁸ However, if a state's per capita income exceeds the national average then the share is lower but it cannot drop below the statutory floor of 50 percent.¹³⁹ Inversely, poorer states have an increased federal share with a statutory ceiling of 83 percent.¹⁴⁰ The share paid the federal government is 100 percent minus the state share with a minimum of 50 percent and maximum of 83 percent.¹⁴¹ For Fiscal Year 2013, the FMAP varied across states from a floor of 50 percent which had a multiplier effect of \$1 in federal funding per \$1 of state spending on Medicaid compared to a high of 73.4 percent which was \$2.76 in federal funding per \$1 in state spending.¹⁴²

B. The Concern of Vulnerability Surrounding the Medicaid Expansion:

¹³⁵ Section 1905(b) of the Social Security Act specifies the formula for calculating FMAPs as follows: “Federal medical assistance percentage” for any State shall be 100 per centum less the State percentage; and the State percentage shall be that percentage which bears the same ratio to 45 per centum as the square of the per capita income of such State bears to the square of the per capita income of the continental United States (including Alaska) and Hawaii; except that (1) the Federal medical assistance percentage shall in no case be less than 50 per centum or more than 83 per centum, (2) the Federal medical assistance percentage for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa shall be 55 percent...”.

¹³⁶ Harvey L. McCormick, *General State Plan Requirement Provisions*, Medicare and Medicaid Claims and Proc. § 25:2 (4th ed.) 2011.

¹³⁷ *Id.*

¹³⁸ *Id.*

¹³⁹ *Id.*

¹⁴⁰ Harvey L. McCormick, *General State Plan Requirement Provisions*, Medicare and Medicaid Claims and Proc. § 22:31 (4th ed.) 2011 (The mathematical formula for determining the state's share is as follows: Share = [(State per capita income)² / (National per capita income)²] × 45 percent).

¹⁴¹ Harvey L. McCormick, *General State Plan Requirement Provisions*, Medicare and Medicaid Claims and Proc. § 25:2 (4th ed.) 2011.

¹⁴² See *Medicaid Financing: An Overview of the Federal Medicaid Matching Rate (FMAP)*, KAISER COMMISSION ON MEDICAID AND THE UNINSURED (September 2012) available at <http://www.kff.org/medicaid/8352.cfm>.

Significantly reducing the number of uninsured individuals in the United States is the central focus of the Patient Protection and Affordable Care Act. (ACA) A vital component in this attempt to expand the continuum of coverage options is the Medicaid expansion.¹⁴³ "The ACA Medicaid expansion aims to extend Medicaid coverage to most low-income people.¹⁴⁴ Specifically, beginning in 2014, the ACA expands Medicaid eligibility to 138% of the federal poverty level (FPL) (\$15,415 for an individual or \$26,344 for a family of three in 2012) for citizens and qualified immigrants."¹⁴⁵ Despite the Supreme Court decision which allows states to opt out of the expansion, Medicaid enrollee numbers are multiplying at a rapid rate.¹⁴⁶ An estimated 21.3 million will enroll by 2022; 1.1 million to 1.8 million people enrolled in Medicaid from October 2013 to December 2013 because of the ACA.¹⁴⁷ In the year 2022, if all states expand Medicaid under the ACA, spending would increase by nearly 1 trillion dollars, 76 billion of that portion would be a state share.¹⁴⁸

The concern is vulnerability.¹⁴⁹ Higher enrollments and increased spending will spark more state Medicaid fraud and abuse activities.¹⁵⁰ For over a decade, Medicaid has remained on the Government Accountability Office's list of high risk programs.¹⁵¹ Coupled with the

¹⁴³ John Holahan et al, *The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis*, THE KAISER COMMISSION ON MEDICAID AND UNINSURED, 1 (November 2012) available at http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8384_es.pdf.

¹⁴⁴ *Id.*

¹⁴⁵ *Id.* at 3.

¹⁴⁶ *Id.* at 1

¹⁴⁷ *Id.* at 1; Ashley Fuoco, *Study: 1M-2M Enrolled in Medicaid Because of ACA*, AMERICAN HEALTH LINE, (Feb. 6, 2014) <http://www.americanhealthline.com/todays-news/2014/02/06/study-1m-2m-enrolled-in-medicaid>.

¹⁴⁸ John Holahan et al, *The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis*, THE KAISER COMMISSION ON MEDICAID AND UNINSURED, 3 (November 2012) available at http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8384_es.pdf.

¹⁴⁹ Peyton M. Sturges & Mary Ann Pazanowski, *Health Plan Regulation, Medicaid Top List Of Issues for 2014 Amid ACA Uncertainty*, 23 HLR 41, (2014).

¹⁵⁰ *Id.*

¹⁵¹ *States' Efforts to Maximize Federal Reimbursements Highlight Need for Improved Federal Oversight: Testimony Before the Comm. on Fin., 109th Cong. 1 (2005)* (statement of Kathryn G. Allen, Dir., Health Care)

complexity of the program, Medicaid spending has grown exponentially, 450 percent over the past two decades.¹⁵² In 2011, the Centers for Medicare & Medicaid Services (CMS), the federal agency within the Department of Health and Human Services (HHS) that oversees Medicaid, estimated that \$21.9 billion (8.1 percent) of federal Medicaid expenditures for that fiscal year were improper payments, fraudulent billings,—the second-highest of any federal program that reports such data.¹⁵³ In the 2012 fiscal year, the Department of Health and Human Services reported that Medicaid expenditures are projected to increase 1.1 percent to \$43 billion in the next 10 years.¹⁵⁴ The Federal government is projected to pay \$248.3 billion, about 57 percent.¹⁵⁵ Due to this high amount of spending, the Government Accountability Office (GAO) has consistently designated Medicare and Medicaid as high-risk programs, “in part due to their susceptibility to improper payments.”¹⁵⁶ The GAO classifies Medicaid as high risk because payments are made in error due to causes like submission of duplicate claims or fraud, waste, and abuse.¹⁵⁷ In an April 2012 study, former CMS Administrator Donald M. Berwick and RAND Corporation analyst Andrew D. Hackbarth estimated that fraud and abuse added as much as \$98 billion to Medicare and Medicaid spending in 2011— more than \$30 billion over CMS

¹⁵² Truffer et al., *2012 Actuarial Report on the Financial Outlook for Medicaid*, iii, Department of Health & Human Services, (2012), <http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Downloads/medicaid-actuarial-report-2012.pdf> l.

¹⁵³ *Medicaid Program Integrity, Expanded Federal Role Presents Challenges to and Opportunities for Assisting State: Testimony Before the Subcommittees on Government Organization, Efficiency and Financial Management and Health Care, District of Columbia, Census and the National Archives, Committee on Oversight and Government Reform, House of Reps.*, 112th Cong. 1 (2011) (Statement of Carolyn L. Yocom, Dir., Health Care)

¹⁵⁴ *Id.*

¹⁵⁵ *Id.*

¹⁵⁶ See generally PATRICIA A. DAVIS ET. AL, CONG. RESEARCH SERV., R40425, MEDICARE PRIMER (January 31, 2013) (Medicare is a federal program that pays for covered health care services of qualified beneficiaries. It was established in 1965 under Title XVIII of the Social Security Act to provide health insurance to individuals 65 and older and has expanded over the years to include permanently disabled individuals under 65. Medicare consists of four parts, (A-D), which covers hospitalizations, prescription drugs, skilled nursing facility care, home health visits, and hospice care.)

¹⁵⁷ *Fostering Innovation to Fight Waste, Fraud and Abuse in Health Care: Before Comm. on Energy and Commerce*, 113th Cong. (2013)

estimates for that same year.¹⁵⁸ A second study from the Institute of Medicine, estimated health care fraud at \$75 billion a year and found that about 30 percent of total U.S. health spending in 2009 -- roughly \$750 billion -- was wasted on unnecessary services, excessive administrative costs, fraud and other problems.¹⁵⁹

The Committee on Oversight and Government Reform Staff Report addressed the evolving issue of fraud within our nation in fiscal year 2012.¹⁶⁰ The report highlighted examples of states whose experiences underscore how fraud bleeds through America's health care system.¹⁶¹ The Department of Health and Human Services Inspector General audited New York's Medicaid services between 2004 and 2006.¹⁶² It was estimated that New York City improperly claimed over 275 million in Medicaid funds for personal care services.¹⁶³ A second audit of New York State revealed the same rampant fraud; 207 million was improperly claimed for rehabilitative care between 2004 and 2007.¹⁶⁴ The amount lost to fraud and abuse is currently unknown but it is speculated to exceed 100 billion dollars a year.¹⁶⁵ The problem seems to be

¹⁵⁸ Donald M. Berwick, MD, MPP; Andrew D. Hackbarth, M Phil, "Eliminating Waste in US Health Care," JAMA. 2012; 307(14):1513-1516. doi:10.1001/jama.2012.362, available at:

<http://jama.jamanetwork.com/article.aspx?articleid=1148376>.

¹⁵⁹ Mark Smith, Robert Saunders, Leigh Stuckhardt, J. Michael McGinnis, Editors, *Best Care at Lower Cost: The Path to Continuously Learning Health Care in America*; Committee on the Learning Health Care System in America; Institute of Medicine.

¹⁶⁰ *Uncovering Waste, Fraud, and Abuse in the Medicaid Program*: Staff Report Before the Comm. on Oversight & Govt. Reform, 112th Cong. 1 (2012), available at <http://oversight.house.gov/wp-content/uploads/2012/04/Uncovering-Waste-Fraud-and-Abuse-in-the-Medicaid-Program-Final-3.pdf>.

¹⁶¹ *Id.* at 9

¹⁶² *See Id.* at 14 citing 9 Daniel R. Levinson, HHS OIG REVIEW OF PERSONAL CARE SERVICES CLAIMS MADE BY PROVIDERS IN NEW YORK (A-02-07-01054), OFFICE OF THE INSPECTOR GENERAL, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES (June 3, 2009), available at <http://www.oig.hhs.gov/oas/reports/region2/20701054.pdf>.

¹⁶³ *Id.*

¹⁶⁴ *See Id.* at 14 citing Daniel R. Levinson, REVIEW OF MEDICAID PERSONAL CARE SERVICES CLAIMS MADE BY PROVIDERS IN NEW YORK CITY, OFFICE OF THE INSPECTOR GENERAL, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES (December 30, 2010), available at <http://oig.hhs.gov/oas/reports/region2/20801006.pdf>.

¹⁶⁵ *Uncovering Waste, Fraud, and Abuse in the Medicaid Program*: Staff Report Before the Comm. on Oversight & Govt. Reform, 112th Cong. 1 (2012), available at <http://oversight.house.gov/wp-content/uploads/2012/04/Uncovering-Waste-Fraud-and-Abuse-in-the-Medicaid-Program-Final-3.pdf>.

the uncontrollable enlargement of the program. Medicaid has grown so large and so complex that it is unmanageable at the federal level alone.¹⁶⁶

C. State False Claims Acts as a Solution for Regaining Medicaid Funds Lost to Fraud:

The Deficit Reduction Act of 2005 created the Medicaid Integrity Program, and included specific appropriations to reduce fraud, waste, and abuse in Medicaid.¹⁶⁷ Five years later, the Patient Protection and Affordable Care Act continued the campaign, thus providing further funding for efforts that are designed to address fraud, waste, and abuse in the Medicaid and Medicare programs.¹⁶⁸ "However, owing to the size and scope of Medicare and Medicaid, reducing improper payments and addressing fraud, waste, and abuse in these programs are continuing challenges for CMS."¹⁶⁹ Public Citizen reported that the most common violation within the fraud context is the overcharging of government health insurance programs, mainly drug pricing fraud against state Medicaid programs.¹⁷⁰ It is imperative that states enact False Claims Acts, as well as update their existing statutes to comply with the OIG guidelines in order to maximize their recovery efforts and recoup money lost to Medicaid fraud.

Since 2001, Arkansas, Louisiana and South Carolina have recovered between 6 percent to 51 percent of their Medicaid program's spending on prescription drug expenditures.¹⁷¹ Three more states, Colorado, Montana, and Rhode Island received letters from the Department of

¹⁶⁶ *Id.*

¹⁶⁷ *Medicaid Program Integrity, Expanded Federal Role Presents Challenges to and Opportunities for Assisting State: Testimony Before the Subcommittees on Government Organization, Efficiency and Financial Management and Health Care, District of Columbia, Census and the National Archives, Committee on Oversight and Government Reform, House of Reps.*, 112th Cong. 1 (2011) (Statement of Carolyn L. Yocom, Dir., Health Care), available at <http://www.gao.gov/products/GAO-12-288T>.

¹⁶⁸ *Id.* at 2

¹⁶⁹ *Id.*

¹⁷⁰ *Id.* at 5

¹⁷¹ Sammy Almashat M.D. & Sidney Wolfe, M.D., *Pharmaceutical Industry Criminal and Civil Penalties: An Update*, PUBLIC CITIZEN, Sept. 27, 2012, available at <http://www.citizen.org/documents/2073.pdf>.

Health in October, 2013, that their False Claims Acts met the federal requirements entitling them to the Medicaid incentive payments.¹⁷² The data compiled in the chart depicts the increase in the amount of money that states are recouping through robust implementation and application of their False Claims Acts.¹⁷³ Adopting a mirror False Claims Act with a broader liability provision and rewarding qui tam provisions provides the statutory authority, and budgetary resources that allows for investigators, attorneys and others to successfully detect fraud. Recent hearings before the House of Representatives suggest two possibilities for eliminating fraud and abuse within the Medicaid program.¹⁷⁴ The first is the Medicaid Integrity Program, which educates State employees through specific coursework in specialized skills in Medicaid fraud detection, investigative data collaboration, and predictive analytics.¹⁷⁵ The second is transparency: working with the Centers for Medicaid and Medicare to create a data sharing system that prevent healthcare providers banned from one state's Medicaid program from trying to fraudulently bill another state's program.¹⁷⁶ However, implementation of these programs as methods to fight waste and abuse do not seem to be as successful, and efficient in weeding out the banned providers who continue to defraud the system.¹⁷⁷

Augmenting federal oversight along with state programs requires a substantial budget, and the state False Claims Acts need to be given serious consideration as the tools for providing

¹⁷² James Swann, *False Claims Acts in Three States Meet OIG Requirements for Medicaid Incentives*, Bloomberg BNA, Oct. 29, 2013, available at http://healthlawrc.bna.com.ezproxy.shu.edu/hlrc/display/story_list.adp?mode=ep&frag_id=37688968&item=topic5&prod=hfln.

¹⁷³ See *supra* Part III.

¹⁷⁴ Fostering Innovation to Fight Waste, Fraud, and Abuse in Health Care, *Hearing Before the Subcommittee on Energy and Commerce*, 113th Cong. 1 (2013), available at <http://www.gpo.gov/fdsys/pkg/CHRG-113hrg80160/pdf/CHRG-113hrg80160.pdf>.

¹⁷⁵ Fostering Innovation to Fight Waste, Fraud, and Abuse in Health Care, *Testimony Before the Subcommittee on Energy and Commerce*, 113th Cong. 1 (2013) at 4-5 (Peter Budetti, Deputy Admin. & Dir. Center for Program Integrity, CMS) available at <http://www.gpo.gov/fdsys/pkg/CHRG-113hrg80160/pdf/CHRG-113hrg80160.pdf>.

¹⁷⁶ M.B. Pell, *U.S. Database for tracking Medicaid frauds falls short, auditor says*, REUTERS, (Mar. 27, 2014) <http://www.reuters.com/article/2014/03/27/usa-medicaid-database-idUSL1N0MM1OK20140327>.

¹⁷⁷ *Id.*

the extra calculation of returns to better fund the efforts against fraud. States who have enacted compliant False Claims Acts, earning the Medicaid incentive payment, can allot up to 10 percent more in their Medicaid budgets.¹⁷⁸ Other states who are not DRA compliant, leave millions of dollars on the table.¹⁷⁹ "With Medicare facing insolvency and Medicaid consuming increasing amounts of state dollars, Congress has a duty to ensure federal program integrity efforts to reduce waste and fraud that are effective and efficient."¹⁸⁰ Tremendous potential to reduce waste and fraud rests in the state False Claims Acts. State False Claims Acts must be given serious consideration because the extra money received through the DRA incentive greatly enhances the funds available, which will strengthen the states' fraud fighting budgets, thus providing an inherent, yet unrealized reinforcement that can help alleviate Congress's expressed concern. Fraud fighting efforts are evolutionary.¹⁸¹ The state survey chart and the settlement numbers are illustrative of the increase in activity and increasing success of the state False Claims Acts. States must continue to participate in national cases against pharmaceutical companies, but states should develop a rigorous program that turns an eye towards bringing false claims against providers such as pharmacies, practitioners, and hospitals. The data provided in this Note, coupled with the existing ethos to fight healthcare and Medicaid fraud warrants aggressive use of state False Claims Acts.

V. CONCLUSION:

Once known as Lincoln's Law, the False Claims Act has evolved over the past 25 years into a powerful weapon to fight fraud within the healthcare industry. In an effort to combat

¹⁷⁸ See *supra* Part II.A.

¹⁷⁹ See *supra* Part II.A.

¹⁸⁰ Press Release, *Bipartisan Finance Committee Members Release Recommendations to Combat Waste, Fraud, & Abuse in Medicare & Medicaid*, The United States Senate Committee on Finance, Jan. 31, 2013, available at <http://www.finance.senate.gov/newsroom/ranking/release/?id=c722ef46-c73d-4323-965e-14a97234992f>.

¹⁸¹ Telephone Interview with John Krayniak, Retired Asst. Att. General of New Jersey, (Mar. 27, 2014).

waste, fraud, and abuse, the government realized it could do more to maximize the False Claims Act's potential. Yet, a state who simply enacts a False Claims Act that is compliant with the Deficit Reduction Act does not necessarily gain increased funds. Ultimately states should consider investing more time and more effort into fighting fraud, and thus understanding that it is imperative to create state False Claims Acts but to also earn the federal incentive through compliance. With the Medicaid expansion looming, more states will feel the demand and desire to invest more funds in fraud investigations. The battle between the government, states, and pharmaceutical companies continues to be fought and litigated vigorously. The False Claims Act has been very to strengthen compliance at a more localized level. To the extent that states emulate the Federal False Claims Act and embed a solid foundational structure to prosecute fraud, Congress and the government successful and it has increased potential if the states pursue an initiative that is narrowly tailored will have another outlet that can foster more resources used to recover tax payer dollars. As Medicaid expands, so does the worrisome concern that fraudulent billing, wasteful behavior, and rampant abuse will seep in through the cracks and go unnoticed. The increased settlement amounts are illustrative of how state False Claims Act can work to prevent such warranted fears. Charles Darwin asserted, "In the long history of humankind, those who learned to collaborate and improvise most effectively have prevailed."¹⁸² State False Claims Act are a fraud fighting mechanism that needs to continue evolving. Increased enactment and DRA compliance can significantly allow states to prosecute Medicaid fraud, recoup monies lost, and allow for creation of a separate budget to strength local and national programs geared towards deterring Medicaid fraud. Such collaboration and improvising

¹⁸² Charles Darwin Quotes, Brainy Quote, http://www.brainyquote.com/quotes/authors/c/charles_darwin.html, (last visited Mar. 26, 2014).

with the government can continue to advance the current methods that are seeking to eliminate fraud in Medicaid and our healthcare system.