Nearly a Perfect 10: The Deficit Reduction Act of 2005 Provides Incentive for Florida to Amend Its Own False Claims Act Legislation

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False claims lawsuits have long been a nemesis of medical providers and those who represent them, while simultaneously offering whistleblowers in the health care field the prospect of substantial financial reward for bringing qui tam actions.\(^1\) Recent federal legislation gave Florida an opportunity to receive increased revenues from successful false claims prosecutions in exchange for strengthening the state False Claims Act. Florida failed to satisfy federal standards in its initial attempt to amend its False Claims Act, but simple amendments to existing Florida law should remedy this defect. The changes would likely boost state false claims lawsuits, a development of which practitioners should be aware.

Congress has long provided a cause of action against medical providers who make false claims for reimbursement from federally funded programs. Under the federal False Claims Act, anyone who knowingly submits a false or fraudulent claim to a state Medicaid program must pay three times the federal government’s damages, plus penalties of $5,000 or $10,000 for each false or fraudulent claim.\(^2\) On February 1, 2006, Congress provided an incentive for states to enact their own false claims legislation or improve existing legislation to emulate federal standards by passing Section 6031 of the Deficit Reduction Act of 2005 (the “DRA”).\(^3\) When a state that has its own false claim law is victorious in a false claim prosecution, the state receives a share of the judgment equal to the percentage it contributes to its Medicaid program.\(^4\) The DRA provides an incentive for states to pass their own legislation by stipulating that if a state’s false claims legislation meets certain federally mandated standards, then the state is entitled to a ten percent increase of any amount recovered in a false claims case brought under the state’s false claims act.\(^5\)

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\(^1\) Qui tam actions allow a private individual with knowledge of fraud against the Federal Government to file suit against the alleged wrongdoer(s) in the name of the government. The Federal False Claims Act contains qui tam provisions that encourage private whistleblowers (known as relators) to file Medicare and Medicaid fraud lawsuits on behalf of the government. The Federal False Claims Act allows the Department of Justice to investigate the claims and decide whether to intervene and assume responsibility for the suit. If the government intervenes, the whistleblower is entitled to between fifteen and twenty-five percent (15%-25%) of the damages recovered, depending on the extent that the relator contributed to the case. If the government chooses not to intervene, the whistleblower can continue the case alone and is entitled to receive between twenty-five and thirty percent (25%-30%) of damages awarded. See generally 31 U.S.C. § 3730 (West 2007).


\(^5\) Id.
False Claims Act litigation generates a tremendous amount of money for the Federal Government. The Department of Justice recently announced that it recovered $3.1 billion in false claims awards in fiscal year 2006. Over seventy percent of these recoveries were in health care cases. These numbers are likely to grow once Medicaid providers implement mandatory False Claims Act education for their employees. States, then, are acting in their best interests by choosing to pass their own false claims laws in order to reap some of these huge economic benefits and to ensure that they no longer lose money to false medical claims.

Satisfaction of the requirements necessary to receive the bonus is no easy task. For a state to qualify for the incentive, its law must meet requirements detailed in Section 6031(b) of the DRA. On August 21, 2006, the OIG issued guidance for making its determination as to whether a state’s false claims act meets the requirements of the DRA. Under new provisions enacted in the DRA, the Office of the Inspector General (the “OIG”) must determine whether the state law:

1) Imposes liability upon the medical services provider for knowingly submitting, or causing to be submitted, false or fraudulent claims similar to the Federal False Claims Act;
2) Rewards and facilitates qui tam actions at least as much as the Federal False Claims Act does;
3) Permits suits to be filed under seal for 60 days while being reviewed by the state Attorney General; and
4) Contains a civil penalty than is not less than the penalty authorized by the Federal False Claims Act.

If the OIG finds that the state law meets these requirements, then the state qualifies for the ten percent bonus as long as its legislation was in effect by February 1, 2007.

Ten states submitted false claims acts for OIG review. Of these ten states, only three met all four mandated requirements. Each state received a letter from Inspector General Daniel R. Levinson detailing the OIG’s reasons for acceptance or rejection of its legislation. In a letter dated December 21, 2006 Levinson explained his reasons for denying the current version of Florida’s False Claims Act (“the FFCA”).

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7 Id.
8 Lezlie B. Willis. Money Talks: Congress Spurs States to Implement Their Own False Claims Acts, 3 ABA Health eSource (Jan. 2007).
11 Id.
12 The other nine states who passed related legislation were Massachusetts, Illinois, Tennessee, California, Louisiana, Nevada, Texas, Michigan, and Indiana.
14 The states that met all mandated requirements were Illinois, Massachusetts, and Tennessee.
The OIG identified two problems with the FFCA. First, the DRA requires a state law to “establish liability to the state for ‘false and fraudulent claims’ described in the Federal False Claims Act.” Under the Federal False Claims Act, the OIG stated, liability is created for “knowingly presenting, or causing to be presented, to an officer or employee of the United States Government a false or fraudulent claim for payment or approval.”

The FFCA, on the other hand, mandates that only persons who “knowingly present to cause or be presented to an officer or employee of an agency a false claim for payment or approval” are liable to the State. The FFCA differs from the Federal False Claims Act in that it fails to extend liability for knowingly presenting or causing to be presented fraudulent claims for payment or approval. The Florida Legislature’s failure to add this necessary term presents a direct violation of the OIG’s first of the four requirements for proper state false claims legislation. If “fraudulent” claims are added to those actionable under the FFCA, the law would be broadened significantly by also allowing suits against providers who knowingly offer phony claims to state-funded programs, rather than those who merely provide claims that are false.

The OIG also asserted that Florida’s False Claims Act failed to contain requirements that were “at least as effective in rewarding and facilitating qui tam actions as those described in the Federal False Claims Act.” The OIG explained that the Federal False Claims Act permits an action to be filed no more than six years after the date that the violation was committed, or three years after the date the facts material to the action were discovered or should have been discovered, but “in no event more than ten years after the date of commission of the violation.” The FFCA, by contrast, requires that a cause of action be brought no later than five years after the date of the violation, or no more than two years after the date when facts material to the action are known or should have been known, but no longer than seven years after commission of the violation. The OIG explained that the FFCA would not facilitate qui tam actions as effectively as its federal predecessor, which is in direct contrast with the second of the OIG’s requirements.

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17 FLA. STAT. § 68.082(2)(a).
18 Letter from Daniel Levinson, supra note 15.
19 A “false” claim is one that is untruthful (i.e., a physician makes a claim for payment for services that were never rendered). A “fraudulent” claim is one where services were provided as indicated, but there is some other reason that the provider should not be paid. For example, an internist receives kickbacks for referring patients to a particular cardiologist. If the cardiologist submits Medicare claims for services he renders to patients, his claims are not “false,” as the services have been provided, but the claims violate anti-kickback laws and are thus “fraudulent.” Currently, the FFCA does not meet the requirements of the Federal False Claims Act because it fails to punish “fraudulent” claims. E-mail correspondence with Joan Krause, Professor, University of Houston Law Center, to author (Feb. 15 & 16, 2007); see generally also Joan H. Krause, Promises to Keep: Health Care Providers and the Civil False Claims Act, 23 CARDOZO L. REV. 1365 (2002).
20 Letter from Daniel Levinson, supra note 15.
21 Id.
22 Id.
The OIG allowed the Florida Legislature to amend the issues addressed in its rejection letter. The Florida Legislature could gain great economic benefit by amending the FFCA to meet the requirements outlined by the OIG. If Florida’s false claims legislation is ultimately accepted by the OIG, additional false claims suits will likely be filed in Florida at the state level because Florida’s law will facilitate qui tam actions at least as much as the Federal False Claims Act. Whistleblowers will be more inclined to file suit under state law and work with a state attorney general than deal with federal laws and the Department of Justice. Qui tam plaintiffs will also be motivated to file suit if, under the theory of pendant jurisdiction, they can recover under both state and federal law.

It is clear that Congress intends for states to enact false claims laws that mirror the Federal False Claims Act. Through the DRA, Congress has increased the value of false claims legislation, investigations, and litigation to Florida. Assuming that the Florida legislature amends the FFCA to meet the requirements mandated by the OIG, medical providers should expect to see states expand their false claims investigations and institute civil cases in the near future. If the OIG accepts an amended version of the FFCA, those who represent providers of medical care will likely find themselves on both sides of an increase in state-level false claim suits in Florida, and should therefore remain aware of any FFCA legislative changes.

February 2007

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23 Id.
24 Corrigan & Cortez, supra note 4, at 513.