McDermott Will & Emery

Quest's $241 Million Medi-Cal Settlement: Medi-Cal "Best Price" and the California False Claims Act

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Quest Diagnostic, Inc.'s recent $241 million Medi-Cal settlement under the California False Claims Act suggests that (1) failing to offer Medi-Cal the lowest wholesale price offered to other purchasers of health care items and services may violate Medi-Cal rules; and (2) providing discounts to referral sources creates a risk of a Medi-Cal anti-kickback "swap" violation. Recent California activity underscores the need to review arrangements not only with respect to Medicare, but also Medi-Cal and private insurers.

On May 19, 2011, Quest Diagnostics, Inc., California's leading provider of medical laboratory testing, agreed to a $241 million settlement with the State of California over alleged violations of California Government Code Section 12651 *et seq.* (the California False Claims Act). According to the California Attorney General's Office, this settlement is the largest recovery in the history of the California False Claims Act.

This settlement is the result of a *qui tam* lawsuit originally filed in 2005 by an independent laboratory against Quest Diagnostics, Inc., four of its affiliates (Quest) and six other medical laboratories. The relator claimed that it was unable to compete in the marketplace because many of the major players were violating the California False Claims Act with unfair laboratory billing practices and illegal kickbacks. The California Attorney General's Office joined the lawsuit in 2009 to recover funds paid in connection with these alleged violations for California's Medicaid program (Medi-Cal). The plaintiffs' primary allegations were as follows:

- The plaintiffs alleged that the defendants submitted false claims for Medi-Cal covered laboratory tests by falsely representing that the fees charged to Medi-Cal were no greater than the best price available to other purchasers of the laboratory tests (*e.g.,* private physicians, clinics, hospitals, independent physician associations, group purchasing organizations (GPOs) and other providers) in violation of California Code of Regulations, Title 22, Section 51501. Section 51501 requires that "no provider shall charge [Medi-Cal] for any service or any article more than would have been charged for the same service or article to other purchasers of comparable services or articles under comparable circumstances." In one example alleged in the complaint, Quest charged Medi-Cal $8.59 to perform a complete blood count test, while charging some of its other customers $1.43 for the same test.
- The plaintiffs further alleged that the defendants gave kickbacks in the form of steep discounts to private physicians, clinics, hospitals, independent physician associations, GPOs and other providers in order to induce referrals for business directly billed by the lab to payors in violation of California Business & Professions Code Section 650 and Welfare & Institutions Code Section 14107.2. Section

650 provides that "the offer delivery, request, or acceptance by any person licensed under this division [i.e., the Medical Practice Act] or the Chiropractic Initiative Act of any rebate, refund, commission, preference, patronage dividend, discount or other consideration, whether in the form of money or otherwise, as compensation or inducement for referring patients, clients or customers to any person, irrespective of any membership, proprietary interest, or coownership in or with any person to whom these patients, clients or customers are referred is unlawful." Section 14107.2 prohibits Medi-Cal providers from soliciting or receiving "any kickback, bribe, or rebate, directly or indirectly, overtly or covertly, in cash or in valuable consideration of any kind…in return for the referral, or promised referral, of any person for the furnishing…of any service" covered by Medi-Cal. The complaint also alleged that any Medi-Cal claims submitted in connection with the illegally referred health care items and services were false claims.

Under the May 19, 2011 Settlement Agreement and Release entered into by the state, the *qui tam* relators and Quest, Quest agreed to:

- Pay $241 million to the state and the *qui tam* plaintiffs, $171 million of which is going to the state; and
- Comply with certain reporting requirements regarding Quest's billings during the time periods identified in the Settlement Agreement, the last of which ends December 2013. In lieu of submitting information for the first five reporting periods in the Settlement Agreement and Release, Quest has the option of submitting Medi-Cal claims at no more than 85% of Medi-Cal's then otherwise applicable published fee schedule for eligible and proper Medi-Cal claims for tests or services from May 1, 2011 through July 31, 2012.

In addition to the releases made by each party, the state agreed not to suspend, exclude, debar or deactivate Quest's Medi-Cal provider numbers for the alleged violations.

Implications of the Lawsuit and Settlement

California regulators have interpreted California Code of Regulations, Title 22, Section 51501 to mean that Medi-Cal providers must offer Medi-Cal their lowest wholesale fees charged to GPOs, health care providers and other purchasers of Medi-Cal covered items and services. The complaint and settlement are silent as to whether Quest was charging Medi-Cal a fee comparable to what it was charging other third party payors (*i.e.,* the lowest retail price) or whether the lowest fee charged to other purchasers was the result of volume discounts or other payer-neutral commercial arrangements. However, in light of the complaint and resulting settlement, providers may want to evaluate whether there is a charge differential between their Medi-Cal charges and charges to other purchasers, including "wholesale" purchasers such as physicians and clinics.

On the anti-kickback side, the state's position with respect to the alleged anti-kickback violations signifies the state's willingness to use anti-kickback violations to bootstrap California False Claims Act actions (*i.e.*, any claim submitted in connection with an illegal referral under the anti-kickback statute is also a false claim). This legal theory is already well accepted under federal law.

What's Next?

Similar California False Claims Act cases are currently pending against other defendants, including Laboratory Corporation of America, California's second largest provider of laboratory services.

In addition to Medi-Cal *qui tam* actions, California may also see a rise in *qui tam* lawsuits filed under California Insurance Code Section 1871.7, California's false claims statute with respect to private payer claims. The California Insurance Commissioner recently intervened in a *qui tam* lawsuit filed against Bristol Myers Squibb, Inc. (BMS). BMS is accused of providing incentives to health care providers that resulted in the submission of false claims to *private payer*s. This BMS case is currently pending in the Los Angeles Superior Court. Health care providers are well-advised to evaluate whether they have effective compliance controls in place for both their governmental and private payer businesses.