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Maryland Health Care Fraud and Abuse Tools: The State False Health Claims Act and Office of Inspector General [Ober|Kaler]

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Fraud and abuse investigation and enforcement, and related expectations for corporate compliance, are now embedded in the fabric of the health care delivery system. Much of the attention focuses on federal law and enforcement agencies collaboratively deploying a myriad of tools to enforce various overlapping laws. Attorneys advising health care providers must bear in mind that state laws and enforcement agencies also have a mission and interest in these activities. This article highlights the work of the Maryland Office of Inspector General (MOIG) of the state Department of Health and Mental Hygiene (DHMH) and the enforcement of the Maryland False Health Claims Act by the Medicaid Fraud Control Unit (MFCU).

The Maryland Office of the Inspector General

The MOIG is a substantial, active arm of DHMH. Its responsibilities include responding to investigations of provider adherence to Medical Assistance Program ("Medicaid") conditions of participation, coverage and related billing rules. Its duties can also include investigations of provider or contractor compliance with the terms of agreements with DHMH, such as where DHMH has funded research or other programs. Health care providers in Maryland and their legal counsel are far more likely to engage with this agency than federal enforcement agencies.

The governing statute for the MOIG is Health-General Article, Title 2, Subtitle 5, of the Annotated Code of Maryland. The definitions of a "claim," "fraud" and "abuse" for the purposes of the MOIG's authority are established under Section 2-501. Interestingly, among the duties of the MOIG under Section 2-503 is to "cooperate with and coordinate investigative efforts with departmental programs and other State and federal agencies to ensure a provider is not subject to duplicative audits." An additional duty of the MOIG under Section 2-504 is the duty to act in collaboration with the appropriate departmental program, so that it may: "(1) Take necessary steps to recover any mistaken claims paid or payments obtained in error or fraudulent claims paid to or obtained by a provider; and (2) Take necessary steps to recover the cost of benefits mistakenly paid or obtained in error, or fraudulently paid to or obtained by a recipient."

Section 2-505 outlines the extensive whistleblower protections, education and notice requirements pertaining to individuals reporting or participating in investigations of fraud or abuse.

The MOIG's stated mission is to "Rio protect the integrity of the Department of Health and Mental Hygiene (DHMH) and promote standards that benefit the citizens of Maryland and program beneficiaries." Its vision is "[t]o be a source of objective, relevant and reliable information in assessing the business practices of DHMH internal and external customers.

The MOIG identifies its "Key Services" on the DHMH website as:

- "Perform periodic examinations and follow-up reviews of the accounts, records, procedures, and policies of DHMH administrations, facilities, and local health departments.
- Prevent fraud, waste, and abuse of departmental funds;
- Ensure the Department and its employees comply with all applicable State and federal law and regulation in its billing practices;
- Ensure that private health information Entrusted to the Department is appropriately protected from disclosure;
- Ensure that human subject research funded by the Department is conducted according to State and federal law and regulation; and
- Provide education and training for employees and providers"

On the DHMH organization chart, the MOIG reports directly to the Secretary. It has its own staff and counsel through the Office of the Attorney General and coordinates closely with the Medicaid Fraud Control Unit in the Office of the Attorney General. It is essential to appreciate the degree to which there is not only internal state agency coordination between the MOIG and OAG, but also close collaboration between the MOIG and federal enforcement agencies such as the Office of Inspector General, U.S. Department of Health and Human Services, the U.S. Department of Justice including the U.S. Attorney's Office, the Federal Bureau of Investigation and other agencies.

One of the more common tools the MOIG uses is an investigative report that the MOIG may develop using internal resources or with the assistance of outside contractors reviewing a Medicaid provider's claims to and payments from the program. The report summarizes the regulations and policies governing a service and details the reasons why it contends that the service was not provided in compliance with said regulations and policies. A draft report is forwarded to the unit within DHMH that regulates that service or establishes the payment rules for the service, to ensure that the MOIG is interpreting everything correctly. The report will include recommended findings and recovery to be sought from the provider. The DHMH unit will advise if it agrees with the MOIG findings and recommendations. At that point, a copy of the report is forwarded to MFCU to ascertain if a criminal or civil action will be pursued by their office. The Department will not seek recovery until or unless MFCU declines to pursue a case against the provider.

According to information made available from the MOIG under a 2011 Public Information Act request, the MOIG conducts a 13-step audit and follow up process. There is a separate Pharmacy Investigations Protocol. The general audit may include the following information and steps:

1. Identification of the Case Source, which may be from a complaint, data mining or results of a claims review algorithm.
2. A Triage and Assessment process, with limited document and policy review.
3. An internal Decision, which can include closing the review, opening a full audit or treating it as a "small review"
4. If the decision is to pursue an audit, this may lead to a Preliminary Audit Activity, including identification of the audit to a work group, review of a sample, review of surveys from the Office of Health Care Quality (OHCQ).
5. Conducting the Audit, which may include engaging support and performing an onsite review.
6. The MOIG indicates that during the audit there may be no contact with the provider about the audit by the DHMH program unit involved.
7. The Tracks Progress, including identifying when the applicable DHMH program has changed or will change its policies and regulations.
8. The MOIG Issues Reports to applicable units within DHMH. Claim-by-claim findings are reported. Where there is to be a recovery from the provider, the MFCU receives the information and a copy of the report.

9. The MOIG will provide the applicable DHMH Program with 30 days to review the report with an opportunity for an extension. The MOIG may issue a recovery letter if the DHMH program agrees with the findings or fails to respond. The MFCU must respond before a recovery letter is issued. The MFCU attempts to respond within 45 days regarding whether it has accepted the case for further investigation. The DHMH Program may disagree with the MOIG's report by the end of the 30 day review period or 60 days if an extension is granted. If disputes cannot be resolved they are referred to the DHMH Deputy Secretary for Operations, and/or the Secretary's Chief of Staff. The MFCU is notified of changes in the report. The MFCU must approve the release of the recovery letter.
10. The MOIG will issue a final Report and Recovery Letter to the provider of services, the DHMH program's executive director, the Medicaid Recoveries Unit and the Appeals Administrator, to OHCQ and to the MFCU.
11. A right to appeals will be provided, through the Office of Administrative Hearings.
12. The MOIG may make a referral to law enforcement agencies including, as applicable, one or more Health Occupations licensing boards, OHCQ and the MFCU.
13. The MOIG will track follow up.

Each case presents its own facts and may lead to deviation from the above process. For example, if upon initial review or after an on-site review, it becomes evident that there is significant evidence of a credible allegation of fraud, a case may be referred and accepted by MFCU without a written report or additional review by MOIG.

A powerful tool available to MOIG involves the interim termination of funding, based on a "credible allegation of fraud." This process is outlined in an April 7, 2011, DHMH memorandum detailing this requirement under the federal health care reform legislation, the Patient Protection and Affordable Care Act (PPACA), section 6402(h)(2) as amended by the Health Care and Education Reconciliation Act of 2010, implemented by February 2, 2011, federal regulations. Under these provisions, where there is evidence of credible allegation of fraud against the Medicaid program, the program must suspend payments to the provider and refer the case to the Medicaid Fraud Control Unit. 42 C.F.R. § 455.23(a) and (d). Payments to the provider will continue to be withheld until it is determined that there is insufficient evidence of fraud or all legal proceedings relating to the alleged fraud are complete. *Id*. § 455.23(c).

A detailed series of questions and answers guiding MOIG's mandatory and discretionary action to identify credible allegations of fraud, impose or defer payment suspensions and make referrals to the MFCU and other law enforcement agencies is contained in a March 25, 2011, guidance document from the federal Centers for Medicare and Medicaid Services. See Letter from Peter Budetti, Center for Program Integrity, and Cindy Mann, Center for Medicaid, CHIP and Survey and Certification. There are provider notice and appeal requirements in the transmittal. Good cause for modifying or staying suspension of payments may be asserted by a provider to whom payments have been suspended.

The MOIG is a funded, staffed, active unit within DHMH with broad authority over DHMH programs and providers. When a health care provider learns of an MOIG audit, it is well advised to take the matter seriously and to recognize this may be just one part of a broader investigation and enforcement action that may involve other federal and state agencies and units. Solid compliance procedures, whistleblower protections and education and training for how to respond to an audit of this kind are advisable, preparatory actions for all health care providers receiving government funds.

If providers and their counsel plan to seek a good cause exception from a payment suspension or other interim sanctions, they will need to ensure that they have or promptly can implement systems that will be accepted as ensuring that no additional improper claims are submitted pending the final outcome of the audit and related appeals. Moreover, the assistance of properly credentialed experts and consultants, access to relevant

medical and billing records and knowledge of applicable regulations as well as government policies and procedures all are components of a successful defense.

In resolving disputes through settlements, it is necessary for health law counsel to be knowledgeable and thoughtful about collateral consequences, such as when reports and updates to CMS form 855 provider enrollment documentation is needed, when a health occupations licensing action may be triggered, and when a resolution will trigger a mandatory or discretionary exclusion from Medicare, Medicaid and other federal and state program participation by the federal OIG.

The Medicaid Fraud Control Unit and the False Health Claims Act

Although MOIG identifies suspected cases of Medicaid fraud, it does not prosecute those cases. That responsibility falls to the Office of the Attorney General, Medicaid Fraud Control Unit. The Unit has statewide authority to prosecute criminal and civil cases involving Medicaid fraud, fraud in the administration of the Medicaid program, the abuse and neglect of vulnerable adults and related crimes. 42 C.F.R. § 1007.11.

The Medicaid Fraud Control Unit receives information about suspected fraud or other violations from a variety of sources. In addition to referrals from MOIG, the Unit receives information from local law enforcement and the ombudsman from the various county Departments of Aging, the Office of Health Care Quality, federal agencies and citizen complaints, among other sources. After it receives information alleging a violation of any statute within its purview, the MFCU will evaluate the information and conduct any necessary investigation. Like MOIG, the Medicaid Fraud Control Unit coordinates closely with federal enforcement agencies and enforcement agencies in other states to promote efficient use of resources and reduce duplication of investigative efforts.

While many attorneys are familiar with the process of a criminal investigation, many may not be aware of new procedures created in the False Health Claims Act. False claims litigation dates back to the Civil War, when companies contracted to supply goods to the Union Army were defrauding the government. *The False Claims Act, A Primer*. This resulted in the enactment of the federal False Claims Act, 31 U.S.C. §§ 3729-3733 ( ). The federal False Claims Act allows the federal government to recover treble damages and additional penalties from anyone found to have submitted a false or fraudulent claim to the federal government. 31 U.S.C. § 3729(a)(1).

The Maryland False Health Claims act became effective on October 1, 2010. It allows the State to recover treble damages and a civil penalty of up to $10,000 per violation from anyone who violates the act. Md. Code Ann., Health-Gen. § 2-602(b) and (c)(2010?). The Maryland act can be violated in nine enumerated ways involving submitting false claims to the State or failing to turn over money or property owed to the State. *Id*. § 2-602(a).

The Maryland False Health Claims Act also contains provisions that allow private citizens, known as relators, who know that false or fraudulent claims have been submitted to the State to file suit on the government's behalf. *Id*. § 2-604(a). These lawsuits, generally known as *qui tam* lawsuits, allow the State to recover money in cases that might not otherwise have come to the government's attention. Anyone who wishes to report suspected fraud may do so without filing a *qui tam* lawsuit. Merely reporting suspected fraud, however, does not entitle one to a share of any eventual recovery obtained by the State. A person can only share in the recovery if he or she becomes a *qui tam* relator and follows all applicable requirements for filing and service.

A relator who seeks to recover under the Maryland False Health Claims Act is required to file a complaint in the name of the State. *Id*. § 2-604(a)(1)(ii). That complaint must be filed under seal and is served only on the State,

not the defendant. *Id*. § 2-604(a)(3). The relator must also serve the State with a statement of "substantially all material evidence and information that the person possesses" regarding the alleged fraud. *Id*.

Complaints and other information should be provided in electronic format whenever possible. Documents should be bates-labeled for ease of reference. If a large number of documents will be produced, an index should be provided. Attorneys representing relators should be alert to the fact that some relators may have privileged information regarding the defendant in a *qui tam* lawsuit. If there is any doubt about whether a relator possesses privileged information, the issue should be discussed with the Medicaid Fraud Control Unit before the information is disclosed.

Because a *qui tam* case is filed under seal, there is no public disclosure of the fact that the case has been filed, the identity of the defendant, or the substance of the allegations until the Court orders the case unsealed. The case remains under seal for at least sixty days to allow the State to investigate the allegations. *Id*. § 2-604(3)(ii)(1).

After investigating, the State will decide whether to intervene and pursue the case further or to decline to intervene in the case. *Id*. § 2-604(a)(6). If the State intervenes, it usually files its own complaint, in which it may adopt some, all, or none of the relator's original allegations. The State may also include additional allegations based on information learned during its investigation. At this point, the case is unsealed. If the State declines to intervene, the court is required to dismiss the case. *Id*. §2-604(a)(7). This is a departure from the federal False Claims Act, which allows a relator to pursue a case even if the government has declined to intervene. 31 U.S.C. § 3730(b)(4)(B).

If the case results in a recovery for the State, the relator is entitled to a portion of the money paid. Generally, a relator may receive between fifteen and twenty-five percent of the recovery. Md. Code Ann., Health-Gen. § 2-605(a)(1)(i). The exact amount is determined on a case-by-case basis after evaluating the time and effort that the relator contributed to the final resolution of the case. *Id*. § 2-605(a)(1)(ii). A relator may be awarded less than fifteen percent of the recovery if lawsuit is based on information disclosed in government reports, hearings, audits or investigations or the news media or if the relator participated in the violations on which the case was based. *Id*. § 2-605(a)(2) and (b).

The False Health Claims Act also created new tools for the Medicaid Fraud Control Unit to investigate alleged false claims. The statute allows the State to seek discovery from any person "during an investigation . . . conducted either independently or in conjunction with a civil action filed under [the False Health Claims Act.]" *Id*. §2-604(b)(2)(i). The Medicaid Fraud Control Unit does not disclose to persons who receive discovery requests whether the information relates to an independent investigation or a *qui tam* lawsuit that is under seal. Targets of investigations that are served with discovery requests usually will not receive a complaint before the State serves discovery requests because an investigation may be preliminary, in which case no complaint has been filed, or the discovery relates to allegations raised in a *qui tam* lawsuit that is under seal. Likewise, witnesses who are served with discovery requests will not receive a subpoena, as every person from whom the State seeks discovery is considered a party to whom no subpoena is required under the Maryland Discovery Rules. *Id*. §2-604(b)(2)(ii). If documents are requested as part of the discovery, they should be provided in electronic format whenever possible and bates-labeled for ease of reference. Providers or counsel with questions about how to produce documents in electronic format should contact the Assistant Attorney General who issued the discovery requests to discuss potential production formats prior to responding to the discovery requests.

Health care providers or others who receive a discovery request from the Medicaid Fraud Control Unit are well advised to take the matter seriously and respond in a timely and thorough manner. Among the factors that can be considered in determining the amount of penalties to be imposed under the Act is "the extent to which the

person otherwise cooperated in the investigation of the violation . . . ." Md. Code Ann., Health-Gen. § 2-602(c)(1)(ix). Health care providers who do not respond appropriately to discovery requests from the Medicaid Fraud Control Unit may be held to account for their lack of cooperation in the form of higher penalties, should they be found to be in violation of the False Health Claims Act.

Both MOIG and the Medicaid Fraud Control Unit are important players in the fight against fraud, waste and abuse in the Medicaid program. Health care providers who are engaged by either agency as part of an audit or investigation should treat the situation with appropriate seriousness. Engaging counsel who is knowledgeable about health care law and government investigations is advisable and can often facilitate the investigative process.