HB 1101

Department of Legislative Services

Maryland General Assembly
2015 Session

FISCAL AND POLICY NOTE

House Bill 1101 (Chair, Health and Government Operations Committee)(By Request - Departmental - Health and Mental Hygiene)

Health and Government Operations

Department of Health and Mental Hygiene - Health Program Integrity and Recovery Activities

This departmental bill authorizes the Inspector General (or a designee) to subpoena any person or evidence, administer oaths, and take depositions and other testimony as part of an investigation of fraud, waste, or abuse. A court of competent jurisdiction may compel compliance. DHMH, the Inspector General, or a departmental contractor or agent may use "extrapolation" to determine the rate of error or overpayment in specified situations. The Secretary of Health and Mental Hygiene or the Inspector General may impose a civil money penalty against a provider for a violation of State or federal law governing the service or item for which the provider submitted a claim and received payment. The Secretary may require a Medicaid provider (or provider applicant) to provide a surety bond or other security in an amount determined by the Department of Health and Mental Hygiene (DHMH); DHMH must adopt regulations to implement the surety bond requirement.

Fiscal Summary

State Effect: General fund revenues increase to the extent civil money penalties are assessed and to the extent DHMH is able to enhance recovery of fraudulent, false, or improper claims from providers. DHMH expenditures (including Medicaid expenditures at a 50% federal matching rate) decline due to reduced audit and litigation costs. Federal matching fund revenues decline accordingly.

Local Effect: The bill is not expected to materially affect local government operations or finances.

Small Business Effect: DHMH has determined that this bill has minimal or no impact on small business (attached). The Department of Legislative Services concurs with this assessment.

Analysis

Bill Summary: "Extrapolation" means a methodology of estimating an unknown value by projecting, with a calculated precision or margin of error, the results of a probability sample to the universe from which the sample was drawn. "Overpayment" means a payment that is made by DHMH to a provider as reimbursement for a health care service or a health care item provided to a participant and is determined, at the time of payment or at a subsequent date, to be inaccurate, in excess, or both, for the procedural code billed or the health care service or health care item provided. The bill clarifies that "program" includes Medicaid managed care organizations.

DHMH, the Inspector General, or a departmental contractor or agent may use "extrapolation" to determine the rate of error or overpayment if (1) required by federal law; (2) there is a determination of a sustained or high rate of payment error; or (3) educational intervention or other action by DHMH has failed to correct the payment error.

A civil money penalty imposed under the bill may not exceed the amount of reimbursement for the paid claim and is *in lieu of* retraction or adjustment of the paid claim. In setting the amount of a penalty, specified factors must be considered. If a civil money penalty is imposed, the Secretary or the Inspector General must issue an order stating (1) the basis for the order; (2) each law violated; (3) each penalty imposed and the total amount of the penalties imposed; (4) the number of claims and total value of the claims identified with errors; and (5) the manner in which the amount of the penalty was calculated. DHMH must provide written notice to a provider of a civil money penalty in a specified manner. A provider may appeal a civil money penalty order under the Administrative Procedure Act (APA). An order imposing a civil money penalty is final when a provider has exhausted all opportunities to contest the penalty under APA. A provider must pay a civil money penalty within 10 days of receiving a final order. All civil money penalties accrue to the general fund. If the provider does not pay a penalty as required, DHMH may file a civil action to recover the penalty.

Current Law: The DHMH Inspector General is authorized to investigate fraud, waste, and abuse of departmental funds. The Inspector General must cooperate with and coordinate investigative efforts with the Medicaid Fraud Control Unit, departmental programs, and other State and federal agencies to ensure a provider is not subject to duplicative audits. The Inspector General may take necessary steps to recover any mistaken claims paid; payments obtained in error; fraudulent claims paid to or obtained by

a provider; or the cost of benefits mistakenly paid, obtained in error, or fraudulently paid to or obtained by a recipient.

The Secretary (or the Secretary's designee) may subpoena any person or evidence, administer oaths, and take depositions and other testimony. If a person fails to comply, on petition of the Secretary or designee, a court of competent jurisdiction may compel obedience to the order or subpoena or compel testimony or the production of evidence.

Background: The bill increases the ability to audit providers that receive funding from the department and to seek recovery for false, fraudulent, or improper claims.

Subpoena Power: Subpoenas are often necessary to obtain documentation needed to investigate a provider. Although the Secretary has subpoena power, it is unclear whether the authority is limited to protecting the health and welfare of the citizens of Maryland. According to DHMH, by providing the Inspector General with subpoena power, there is no question as to whether the documents were obtained legally.

Surety Bonds: When a provider is audited for possible waste, fraud, or abuse and a recovery is sought, it is not uncommon for a provider to claim lack of funds, particularly for incorporated entities. Many providers go out of business, and no recovery can be made. The State is required to return any federal matching funds for claims identified as overpayment to the federal government even if the claims are not recovered from the provider. Federal regulations have been implemented to require suppliers of durable medical equipment, prosthetics, orthotics, and supplies to obtain a minimum of $50,000 in surety bond coverage as a condition of participation in Medicaid and Medicare. Home health agencies are also required to obtain a surety bond. However, the State is not covered by the federally required surety. According to DHMH, a surety bond requirement (likely targeted at certain types of providers) will cover financial liability should a provider owe the State funds.

Extrapolation: Statistical sampling and extrapolation are standard audit practices that reduce the cost of auditing in exchange for accepting a small amount of risk in the audits. Health care audits can include hundreds or thousands of potentially fraudulent claims, which are time consuming and expensive to investigate and litigate. The federal government and at least 11 states use extrapolation when performing Medicaid provider audits. According to DHMH, use of extrapolation based on a statistically sound sample permits DHMH to identify and recoup larger recoveries for fraud, waste, and abuse.

Civil Money Penalties: If a provider submits a claim for payment, the provider is attesting compliance with all laws and regulations. If the provider is in violation of these laws or regulations, DHMH can recoup the entire cost of the claim. However, if a service or good was actually provided and the violation is a technicality or first offense, it may not be fair

to the provider to recoup all of the funds. According to DHMH, civil money penalties provide an alternative penalty to recoupment of the claim and may provide incentive (compared with no recoupment) to the provider to become compliant with laws and regulations.

State Fiscal Effect: General fund revenues increase to the extent DHMH imposes civil money penalties on providers for improper claims in cases in which the claim would not otherwise have been recouped by the department. General fund revenues also increase to the extent DHMH increases recoveries for fraudulent, false, or improper claims.

According to DHMH, the authority to use extrapolation in auditing enhances operational efficiencies and reduces the cost of auditing claims and defending audits in court. The surety bond requirement for Medicaid providers reduces financial liability for DHMH by allowing collection of improper claims and enhancing the ability to return federal matching funds.

In fiscal 2015, the Office of the Inspector General identified $31 million for recovery. Since fiscal 2007, the office has identified over $100 million for recoveries.

Additional Information

Prior Introductions: As introduced, SB 117 of 2006 (Chapter 70 of 2006) required providers to obtain a surety bond to assure that sufficient funds are available to satisfy any recovery amounts. This provision was not included in the Act as enacted.

Cross File: None.

Information Source(s): Department of Health and Mental Hygiene, Judiciary (Administrative Office of the Courts), Department of Legislative Services

Fiscal Note History: First Reader - March 13, 2015
md/ljm

Analysis by: Jennifer B. Chasse

Direct Inquiries to:
(410) 946-5510
(301) 970-5510

ANALYSIS OF ECONOMIC IMPACT ON SMALL BUSINESSES

TITLE OF BILL: Office of Inspector General – Fraud, Waste and Abuse Prevention, Detection and Recovery

BILL NUMBER: HB 1101

PREPARED BY: Susan Steinberg, Office of the Inspector General

PART A. ECONOMIC IMPACT RATING

This agency estimates that the proposed bill:

__X__ WILL HAVE MINIMAL OR NO ECONOMIC IMPACT ON MARYLAND SMALL BUSINESS

OR

___ WILL HAVE MEANINGFUL ECONOMIC IMPACT ON MARYLAND SMALL BUSINESSES

PART B. ECONOMIC IMPACT ANALYSIS

Surety bonds for health care providers in good standing are relatively inexpensive. A $100,000 bond may cost less than $500. Civil penalties would be implemented in lieu of retracting an entire claim for what may be considered minor violations of regulations. Thus, implementation of civil penalty may actually be a savings for the provider community. Extrapolation could have a more substantial impact on the provider community. However, it is only implemented when a provider has a sustained or high level of error in their claims submission.