SB 215

Department of Legislative Services

Maryland General Assembly
2008 Session

FISCAL AND POLICY NOTE

Senate Bill 215 (Chair, Judicial Proceedings Committee)
(By Request – Departmental – Health and Mental Hygiene)

Judicial Proceedings

Maryland False Health Claims Act

This departmental bill • prohibits a person from making a false or fraudulent claim for payment or approval by the State or the Department of Health and Mental Hygiene (DHMH) under a State health plan or program; • authorizes the State to file a civil action against a person who makes a false health claim; • establishes civil penalties for making a false health claim; • permits a private citizen to file a civil action on behalf of the State against a person who has made a false health claim; and • requires the court to award a certain percentage of the proceeds of the action to the private citizen initiating the action.

Fiscal Summary

State Effect: Potentially significant increase in Medicaid general fund recoveries beginning in FY 2009. Potential increase in general fund revenues due to the bill's civil penalty provisions. The amount of any revenue increase cannot be reliably estimated at this time. If the Attorney General receives fewer than 50 complaints per year stemming from this bill, any additional workload could be handled with existing resources.

Local Effect: Potential increase in revenues due to the bill's civil penalty provisions. The amount of any increase cannot be reliably estimated at this time.

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

Analysis

Bill Summary: A "claim" is a request or demand, under contract or otherwise, for money or property made to or by a contractor, grantee, or other person for the provision of services if the State or DHMH, through a State health plan or program, provides or reimburses for any portion of the money or property. A "State health plan" is the State Medical Assistance Plan or a private health insurer, HMO, managed care organization, or health care cooperative or alliance that provides or contracts to provide health care services that are wholly or partly reimbursed by or are a required benefit of a health plan established under the federal Social Security Act or by the State. A "State health program" is the Medical Assistance Program, the Cigarette Restitution Fund Program, the Mental Hygiene Administration, the Developmental Disabilities Administration, the Alcohol and Drug Abuse Administration, the Family Health Administration, the Community Health Administration, or any other unit of DHMH that pays a provider for a service rendered or claimed to have been rendered to a recipient.

The bill prohibits a person from • knowingly presenting or causing to be presented a false or fraudulent claim for payment or approval under a State health plan or program; • knowingly making, using, or causing to be made or used a false record or statement to get a false or fraudulent claim paid or approved; • conspiring to defraud the State or DHMH by getting a false or fraudulent claim approved or paid; • having possession, custody, or control of property or money used or to be used under a State health plan or program with intent to defraud; • being authorized to make or deliver a receipt of property used or to be used under a State health plan or program with intent to defraud; • knowingly buying or receiving publicly owned property from an officer, employee, or agent of a State health plan or program who may not lawfully sell or pledge the property; • knowingly making, using, or causing to be made or used a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property; or • knowingly making any other false or fraudulent claim against a State health plan or program.

The bill authorizes a private party to bring an action on behalf of the State, in which the private party may seek any remedy available in common law tort, compensatory damages to compensate the State, court costs, and attorney's fees. If the State intervenes and proceeds with an action and prevails, the court must award the private party not less than 15% and not more than 25% of the proceeds, and in certain circumstances not more than 10% of the proceeds, proportional to the amount of time and effort that the party contributed to the final resolution of the action. If the State does not intervene and proceed with an action and the private party proceeds and prevails, the court must award the private party not less than 25% and not more than 30% of the proceeds. The court

may reduce the award or dismiss the private party from the action under certain circumstances.

The bill prohibits retaliatory actions by an employer against an employee for • acting lawfully in furtherance of a false claim action; • disclosing the employer's false claim; • providing information or testifying regarding a false claim; or • objecting or refusing to participate in a practice the employee reasonably believes to be a false claim. Remedies provided under the bill are in addition to any other remedy available under State or federal law or any collective bargaining agreement or employee contract.

The statute of limitations for any action brought under the bill is six years from the date of the violation or three years after the date when material facts were known or reasonably should have been known, but in no event more than 10 years after the date on which the violation is committed. In any action, the State or the initiating complainant must prove all essential elements of the case by a preponderance of the evidence.

A person who violates the bill's prohibitions is liable for a civil penalty of not less than $5,000 and not more than $10,000 and either • triple the State's resulting damages; or • under specified circumstances, not less than twice the State's damages.

Current Law: The Medicaid Fraud Control Unit of the Attorney General's Office investigates and prosecutes provider fraud in State Medicaid programs. In addition to any other penalties provided by law, a health care provider that violates a provision of the Medicaid Fraud part of the Criminal Law Article is liable to the State for a civil penalty of not more than triple the amount of the overpayment. If the value of the money, goods, or services involved is $500 or more in the aggregate, a person who violates Medicaid fraud provisions is guilty of a felony and on conviction is subject to imprisonment for up to five years or a fine of up to $100,000 or both. If a violation results in the death of or serious physical injury to a person, the violator is subject to enhanced penalties.

The federal False Claims Act (FCA), 31 U.S.C. § 3729, allows the bringing of a *qui tam* action by a private citizen (relator) on behalf of the federal government, seeking remedies for fraudulent claims against the government. If successful, the relator is entitled to a share of the recovery of federal damages and penalties, depending on the extent to which the relator substantially contributed to the case. Relators are not entitled to a share of a state's portion of recoveries. Many states have enacted state false claims acts under which states must share the damages recovered with the federal government in the same proportion as the federal government's share in the cost of the state Medicaid program.

Background:

Current Medicaid Fraud Control Efforts: DHMH has an Office of the Inspector General (OIG) that works closely with the Medicaid Fraud Control Unit to maximize efforts to contain fraud, waste, and abuse in Medicaid and other departmental programs. Through its efforts under existing law, OIG identified cost avoidance (claims the State would have erroneously paid) totaling $13.4 million in fiscal 2006 and $17.5 million in fiscal 2007.

Federal Incentives: The federal Deficit Reduction Act of 2005 (DRA) established incentives for states to enact certain antifraud legislation modeled after the federal FCA. States that enact qualifying legislation are eligible to receive an increase of 10% of the recovery of funds (by a corresponding 10% reduction in the federal share).

To qualify, a state false claims act must provide • liability to the state for false or fraudulent claims; • provisions for *qui tam* actions to be initiated by whistleblowers and for the rewarding of those whistleblowers in amounts that are at least as effective as those provided by the federal FCA; • the placing of *qui tam* actions under seal for 60 days for review by the state Attorney General; and • civil penalties not less than those provided in the federal FCA, to be imposed on those who have been judicially determined to have filed false claims.

Other States: Twenty states have enacted state false claims acts with *qui tam* provisions, eight of which qualify for increased recoveries under the DRA (Hawaii, Illinois, Massachusetts, New York, Nevada, Tennessee, Texas, and Virginia).

State Revenues:

Medicaid: To the extent that the bill is approved by Office of the Inspector General at the federal Department of Health and Human Services, Medicaid general fund revenues could increase under the bill beginning in fiscal 2009. Under current law, any recoveries must be split 50/50 between the State and federal government. An approved State false claims act would allow the State to retain 60% of recoveries. *For example*, if DHMH were to recover $1.0 million, the State share would be $600,000 under the bill rather than $500,000 under current law.

To the extent that additional false or fraudulent claims are successfully prosecuted under the bill, general fund revenues could increase beginning in fiscal 2009 under the bill's monetary penalty provisions for those cases heard in the District Court.

State Expenditures: According to DHMH, to the extent that the bill generates additional referrals for false or fraudulent claims, additional personnel and resources may

be required by the Office of the Attorney General. The amount of any increase cannot be reliably estimated at this time and would depend on the number of additional referrals. If the Attorney General receives fewer than 50 complaints per year stemming from this bill, any additional workload could be handled with existing resources.

Local Revenues: To the extent that additional false or fraudulent claims are successfully prosecuted under the bill, local revenues could increase under the bill's monetary penalty provisions for those cases heard in the circuit courts.

Additional Information

Prior Introductions: Several similar false claims bills have previously been introduced. SB 367 of 2000 received no action from the Senate Judicial Proceedings Committee. SB 175 of 2001 passed the Senate, but was not acted on by the House Judiciary and Environmental Matters committees. SB 317 of 2002 received an unfavorable report from the Senate Judicial Proceedings Committee. Similar provisions of the bill were included in SB 2 of 2004 as passed by the Senate, but the language was removed in conference committee.

Cross File: None.

Information Source(s): Judiciary (Administrative Office of the Courts), Department of Health and Mental Hygiene, Maryland Insurance Administration, Department of Budget and Management, Office of the Attorney General, Department of Legislative Services

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