HB 304

Department of Legislative Services

Maryland General Assembly
2009 Session

FISCAL AND POLICY NOTE

House Bill 304 (The Speaker, *et al.*) (By Request - Administration)
Judiciary and Appropriations

Maryland False Health Claims Act of 2009

This Administration bill (1) 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; (2) authorizes the State to file a civil action against a person who makes a false health claim; (3) establishes civil penalties for making a false health claim; (4) 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 (5) 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: Potential increase in general fund revenues due to the bill's civil penalty provisions. Potentially significant increase in special fund revenues beginning as early as FY 2010 from an enhanced share of federal Medicaid recoveries and additional volume of recovery filings, with a corresponding increase in special fund expenditures. General fund expenditures decrease due to the availability of additional special funds for Medicaid, the Mental Hygiene Administration, and the Developmental Disabilities Administration. The proposed FY 2010 State budget includes $22.0 million in reductions (50% general funds, 50% federal funds) contingent on enactment of the bill; however, actual savings in FY 2010 and future years cannot be reliably estimated.

Local Effect: The bill does not materially affect local operations or finances.

Small Business Effect: The Administration 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, provider, or other person for the provision of services if the State or DHMH, through a State health plan or program, provides or reimburses any portion of the money or property. A "State health plan" is the State Medicaid program or a private health insurer, health maintenance organization (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 Medicaid, 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 (1) knowingly presenting or causing to be presented a false or fraudulent claim for payment or approval under a State health plan or program; (2) 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; (3) conspiring to defraud the State or DHMH by getting a false or fraudulent claim approved or paid; (4) 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; (5) being authorized to make or deliver a receipt of money or property used or to be used under a State health plan or program with intent to defraud; (6) 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; (7) 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 (8) knowingly making any other false or fraudulent claim against a State health plan or program.

A person who violates the bill's prohibitions is liable to the State for (1) a civil penalty of at least $5,000 and up to $10,000 and triple the State's damages resulting from the violation; or (2) under specified circumstances in which the person cooperates with the State, not less than twice the State's damages and no civil penalty. The State may file a civil action against an alleged violator seeking civil penalties, compensatory damages, and court costs and attorney's fees. Any civil penalties or damages assessed are deposited in the general fund.

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 (1) acting lawfully in furtherance of a false claim action; (2) disclosing or threatening to disclose the employer's false claim; (3) providing information or testifying regarding a false claim; or (4) 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 6 years from the date of the violation or 3 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. A civil action may be filed for activity that occurred prior to October 1, 2009, if the limitations period has not lapsed. In any action, the State or the initiating complainant must prove all essential elements of the case by a preponderance of the evidence.

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 and/or a fine of up to $100,000. 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, $17.5 million in fiscal 2007, and $20.9 million in fiscal 2008.

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 (1) liability to the state for false or fraudulent claims; (2) 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; (3) the placing of *qui tam* actions under seal for 60 days for review by the state Attorney General; and (4) 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-two states and the District of Columbia have enacted state false claims acts with *qui tam* provisions, 13 of which qualify for increased recoveries under DRA (California, Georgia, Hawaii, Illinois, Indiana, Massachusetts, Nevada, New York, Rhode Island, Tennessee, Texas, Virginia, and Wisconsin).

Some states have realized significant savings the year after enacting a state false claims act. However, given that false claims recoveries involve lengthy and complex litigation, it is unclear what portion of those increased recoveries is directly attributable to enactment of a state act rather than large recoveries from existing cases.

Governor's Proposed Fiscal 2010 Budget: The Governor's proposed fiscal 2010 budget includes $22.0 million in reductions (50% general funds, 50% federal funds) contingent on enactment of the Maryland False Claims Act of 2009 (SB 272/HB 304). Of these reductions, $18.0 million are in Medicaid, $2.0 million are in the Mental Hygiene Administration, and $2.0 million are in the Developmental Disabilities Administration.

DHMH indicates that these savings ($11.0 million in general funds) will result due to the 10% enhancement in recoveries under DRA, associated damages in the civil process that cannot be awarded under current law, and additional volume of false claims cases. This figure is based on current fraud collection efforts in Maryland and increased recoveries in other states in the first year following enactment of a state false claims act.

State Revenues: To the extent that the bill is approved by the Office of the Inspector General at the federal Department of Health and Human Services, DHMH revenues increase under the bill beginning as early as fiscal 2010 due to increased fraud recoveries. Under current law, any recoveries must be split evenly 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.

Further, general fund revenues may increase from civil penalties against providers that defraud the State's health plans and programs and from additional volume of false claims filings in the State. Current law does not provide a civil cause of action for fraud against defrauding providers; therefore, the State is only able to recover what it can prove as actual losses. The bill provides a civil cause of action.

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 depends on the number of additional referrals.

For illustrative purposes only, Washington State is currently considering a false claims act (SB 5144). The fiscal note for that bill indicates that 25 new positions would be required "to provide legal services in complex litigation pharmaceutical cases" at an estimated cost of $3.8 million annually.

Additional Information

Prior Introductions: This bill is identical to SB 215 of 2008. SB 215 received a favorable report from the Senate Judicial Proceedings Committee, but failed on third reading.

Cross File: SB 272 (The President, *et al.*) (By Request - Administration) - Judicial Proceedings.

Information Source(s): Department of Budget and Management, Maryland Health Insurance Plan, Department of Health and Mental Hygiene, Maryland Insurance

Administration, Judiciary (Administrative Office of the Courts), Department of Legislative Services

Fiscal Note History: First Reader - March 3, 2009
ncs/mwc

Analysis by: Jennifer B. Chasse

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

ANALYSIS OF ECONOMIC IMPACT ON SMALL BUSINESSES

TITLE OF BILL: Maryland False Health Claims Act of 209

BILL NUMBER: House Bill 304

PREPARED BY: 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

The proposed legislation will have no impact on small business in Maryland.