

SENATE BILL 279

Maryland False Health Claims Act of 2010

Senate Judicial Proceedings Committee

February 23, 2010

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Introduction

We confront today an irrational paradox. As the State makes painful cuts to programs which help thousands of Marylanders, it is at the same time losing millions of dollars through fraud and abuse in its Medicaid program. As we grapple with escalating health care costs, we compound the problem by tolerating a massive waste of scarce resources. As we struggle to devise better ways to ensure and improve quality of care, we allow unnecessary, ineffective, and even harmful medical procedures to go undetected.

While the overwhelming majority of health care providers are honest, enough abuse exists in the health care system that by some estimates, fully 10% of State Medicaid dollars - or roughly \$300 million - are lost to fraud every year. Thousands of health care consumers suffer the consequences of compromised patient safety, fraudulent billing, and suboptimal care. Honest providers stand by helplessly as competitors take more than their share from the system. Taxpayers make up the huge deficits caused by wasted dollars. Fraud and abuse hurts everyone, and we cannot allow it to continue.

Senate Bill 279, the Maryland False Health Claims Act of 2010, will increase exponentially the State's ability to recover these stolen funds, and it will save millions more through deterrence. The federal False Claims Act (FCA) has been characterized as U.S. taxpayers' single most important tool in recouping millions of dollars defrauded from the federal government every year. Since its enactment in 1986, the FCA has returned over \$24 billion to government coffers. For every \$1 spent on fraud enforcement, the government has recovered \$15. Yet the reach of the federal FCA is limited, for the U.S. government typically pursues only the largest, multi-state cases. By

contrast, where states have enacted their own FCAs, they have increased recoveries by as much as 100%. Over half the states have taken advantage of this way to recoup extra dollars, with others like Pennsylvania currently working to join their ranks. In addition, recognizing these lost opportunities, Congress created an incentive under the Deficit Reduction Act (DRA) for states to enact their own FCAs which meet specific requirements. These “DRA-compliant” states receive an additional 10% share of all Medicaid fraud recoveries.

Maryland must now follow suit and join the growing number of states recognizing the value of this additional tool for fighting fraud, protecting patients, and safeguarding public coffers. In partnership with the General Assembly, the Administration has held itself to a high standard in expending taxpayer dollars judiciously and protecting the public fisc. It has worked hard to hold itself accountable to ferret out waste, fraud and abuse across State government. Yet it continues to leave millions of dollars on the table, as Medicaid fraud goes largely unchecked and undeterred. Senate Bill 279 will help stem this bleeding, creating an effective mechanism to recoup stolen funds and a credible deterrent to prevent continued theft and abuse.

Inadequacy of the State’s Legal Remedies

As a practical matter, the State can currently do little more than sit back and watch as millions of dollars stream fraudulently out of the Medicaid program. Its sole recourse is to bring administrative actions against suspected perpetrators, but this laborious, painstaking process limits any recovery to actual losses only, with no penalties or damages to deter repeat offenders. Thus, state enforcement lacks credibility as a deterrent and efficacy as a means of recovering damages. It amounts to little more than an interest-free loan for unscrupulous providers.

What the Bill Would Do

Senate Bill 279 will allow Maryland to protect its Medicaid budget against theft. Like the federal FCA, the bill enables the State to recover treble damages and civil penalties from individuals who knowingly make false claims against State health plans. It permits both the Attorney General and private persons, known as “relators” or “whistleblowers,” to file suit on behalf of the State through a “qui tam” provision. With respect to qui tam actions, it sets forth specific guidelines regarding the Attorney General’s right to intervene, move to dismiss, limit the relator’s participation, and settle the action. It also delineates the circumstances and permissible amount of a relator’s award, and a defendant’s right to recover attorney’s fees and costs for any frivolous actions.

Why the Federal FCA Is Not Sufficient

The State receives a 50% share of actual losses recovered in actions brought under the federal FCA. In addition, although under no legal obligation, the federal government typically allocates to individual states affected by a fraudulent scheme some percentage of any treble damages recovered. This policy notwithstanding, Maryland’s dependence solely on cases brought under the federal FCA leaves it battling fraud with one hand tied behind its back. A state FCA with a qui tam provision would bolster our efforts

substantially by increasing the volume of cases, enhancing detection and prosecution, and creating more effective deterrence.

Facilitating Maryland's Involvement and Control over Federal Cases: First, a state FCA with a qui tam provision would give Maryland an enhanced role and control over federal cases. The Department of Justice pursues for the most part large, multi-state actions against major providers. Affected states which have FCAs are named in these suits. Thus, these states learn of the lawsuits immediately and can lead or participate in state teams which coordinate and make decisions about their investigation and prosecution. They can also take early action, particularly in cases implicating patient care and safety, to put an end to the fraudulent practice underlying the lawsuit. This early notification can help states avoid scenarios like a recent example in which states not named in a federal case under seal remained unaware while the investigation dragged on that pharmacy practices in nursing homes were causing ongoing harm.

Unlike states with FCAs, Maryland is often left in the dark until well after cases are filed and investigated. Thus, Maryland cannot take the lead or even participate in the decision as to whether to pursue any of these federal cases. The State may also lose opportunities to make early efforts to ameliorate harm to patients. Particularly in cases with severe or disproportionate impact on Maryland, this limitation constrains the State's ability to police its own backyard. It leaves to the discretion of the federal government and other states whether a potentially egregious fraud committed here in our own State will be pursued aggressively or left instead to languish or be dismissed.

Second, the Department of Justice has about 1,000 cases under seal in various stages of investigation and development, with several hundred added each year. Without its own FCA, Maryland has no opportunity to take over cases which, for various reasons, the federal government or other affected states may decide to reject or simply not pursue. A recent case against Merck & Co. illustrates this potential for missed opportunity. The case languished for four years at the federal level before it was rejected, only to be revived by the Nevada Attorney General under the State's FCA and settled for \$650 million.

Initiating State Cases: Second, with a state FCA, the Attorney General can initiate and pursue cases on his own where no federal or state relators are involved. The federal government pays for 75% of these enforcement costs through the funding of the Medicaid Fraud Unit.

Critical Public Policy Value of Qui Tam Provision: Finally, in addition to facilitating Maryland's involvement and control in federal suits, other public policy benefits accrue to having a state FCA with a qui tam provision. This key component of the bill also enhances the detection, effective prosecution, and deterrence of fraud here in Maryland, thereby increasing the State's ability to protect its own health care consumers, providers, taxpayers and public coffers. First, because of the complex nature of health care fraud, outside law enforcement entities find it extremely difficult to discover or detect on their own the complicated and often cleverly-disguised fraudulent schemes. Uncovering these

deceptive practices almost always requires employees from within an organization to come forward, for they are the ones who can detect and understand the fraud in the first instance, and they have the unique ability to help develop the evidence necessary to prove it has occurred. Indeed, out of the billions recovered under the federal FCA, the vast majority comes from actions initiated by relators and joined by the government.

Second, the ability of employees to expose fraud serves as a powerful deterrent. It not only acts as a restraint on fraudulent behavior, but also creates additional incentive for providers to establish effective compliance programs to prevent it.

Track Record of Federal and State FCA Recoveries: The actual dollars recovered under the federal and state FCAs bear out their effectiveness in combating and deterring fraud. As stated above, the federal government has recouped \$24 billion since 1986. \$16 billion reflects health care fraud, and \$11.5 billion out of the \$16 billion has been recovered in qui tam cases. In addition, states have obtained between 20%-34% more in recoveries after enacting an FCA with a qui tam. For example, Virginia's recoveries rose from the \$20 million to the \$100 million range in the two years after it enacted an FCA. These states also benefit from the many millions more saved through the substantial fraud deterred by virtue of effective private and public fraud enforcement working together.

What the Bill Would Not Do

Opponents of state FCAs claim that they impose undue burdens on health care providers, particularly small providers which operate close to the margins, by increasing frivolous lawsuits brought by disgruntled employees. They assert also that a state FCA will not increase recoveries because of the offset by the award to the relator. Finally, they argue that under the bill, simple billing mistakes will result in onerous investigations and lawsuits. As explained below, these arguments are simply wrong.

Impact on small providers: The Administration recognizes the special challenges faced by small providers, and it is working on multiple fronts to help small businesses generally. In this specific context, small providers will benefit along with larger ones from the State's ability to use fraud recoveries to offset painful Medicaid budget cuts. In addition, both logic and experience at the federal level and in other states make clear that large fraud occurs most often with large providers, and neither private nor public resources are worth expending to go after smaller impact cases.

At the same time, the Administration understands that small providers' size and operations can create different pressures, and it has worked with representatives to address these concerns. Amendments under discussion, for example, would ensure that in determining the amount of damages assessed against a small provider found to have committed fraud, the court would be required to consider a series of mitigating factors, the lynch pin of which would be whether the damages would compromise the provider's ability to continue operations.

A State FCA will not increase frivolous lawsuits: The federal FCA has precisely the same qui tam provision governing whistleblower actions as does Senate Bill 279. The government's success in ferreting out fraud and recouping stolen dollars is in fact

attributed significantly to the ability of relators to supplement public enforcement efforts. Yet health care providers have been subject to the federal law for over 20 years, and the state FCA will neither impose new liabilities nor create any new rights for whistleblowers. Moreover, both the law and practical realities protect against frivolous lawsuits. First, the State may move to dismiss a relator's frivolous action, and the Court may award attorney's fees and costs to a defendant where a relator has brought frivolous claims. In addition, a whistleblower must have enough evidence to persuade an attorney to take what will often be an extremely lengthy, difficult and complex case, and the evidence must involve new information not previously disclosed in another case or the media. A relator must also be willing to undergo the substantial risk to professional reputation and career, as well as emotional distress inherent in prosecuting such cases. A state FCA will not change any of these dynamics that have existed under the federal FCA for decades.

As a final point, experience under the federal FCA shows that the government's intervention serves most often to separate serious relator cases from weaker ones. Department of Justice data demonstrates that where the government intervenes, the vast majority of cases (over 90%) are successful and result in recoveries, while the balance of relator-initiated actions in which the government declines to intervene do not go forward. In 2009, for example, out of \$1.36 billion in health care fraud qui tam recoveries, all but \$40 million came from cases in which the Department of Justice intervened.

A State FCA will not result in decreased Medicaid fraud recoveries because of relator awards: Opponents claim that a state FCA will actually result in decreased recoveries because of the State's obligation to pay relator awards, which will offset its recovery. States' actual experience under their FCAs, however, does not bear this theory out. Rather, the State's increased recovery with an FCA is not limited to the 10% DRA incentive, but is also substantially greater overall because a state FCA, in addition to resulting in greater recoveries through the assessment of treble damages and fines, increases the volume of cases and the effectiveness of detection and enforcement. First, as stated above, the Attorney General is able to initiate and pursue cases on its own where no relator is involved. Second, the State can take a more active role in pursuing, either in conjunction with the federal government and other states, or on its own, the 1,000 cases currently under seal in federal court and in various stages of investigation and development. Finally, the ability of relators to bring suit enhances the detection of fraud at the local level, and the strength of the evidence proving a fraudulent scheme.

A State FCA will not target simple mistakes or mere negligence: Finally, a state FCA will not result in cases against providers for simple billing mistakes or acts of mere negligence. The bill's language establishing a claim for fraud is identical to that used in the federal statute and almost all other states, where innocent mistakes are not targeted. Because the Administration seeks to allay any concerns about this issue, however, an amendment under consideration would make clear beyond question that mistakes and negligence are not considered fraud.

Benefits to Patients, Health Care Providers, and Taxpayers

The benefits of these fraud recoveries have widespread ripple effects on patients, providers, and taxpayers. First, a state FCA will help level the playing field for honest health care providers. Providers feel the consequences when Medicaid resources are unfairly depleted and their competitors receive more than their fair share of those resources. Second, patients suffer when scarce dollars are drained wastefully from the system through fraudulent billing and other practices that result in decreased quality of care. Recent allegations against a local hospital that hundreds of patients underwent unnecessary invasive and costly medical procedures highlight this harmful consequence of fraud. Third, because the State Medicaid program is such a large payor, detecting and deterring fraud in this public program has beneficial impact on the private sector. Combating fraud is a critical component of our struggle to contain the ongoing rise of health care costs which threatens to bankrupt the entire system. Finally, every stolen dollar returned to State coffers is a dollar not taken from taxpayers' pockets.

Conclusion

In sum, Senate Bill 279 is an effective and reasonable enforcement tool which will significantly improve the State's ability to safeguard the integrity of its Medicaid program. Over half of all other states have ensured they have this tool, and others will soon join their ranks. We should not allow Maryland to lag behind any longer. At a time when every public dollar is precious, it is unconscionable that Medicaid, which is so critical to the health and well-being of Maryland's poorest and most vulnerable, should fall victim to millions of dollars in theft every year. The State must build on its widespread efforts to combat fraud and abuse by rectifying this anomaly. By enabling the State to recover stolen dollars and prevent further fraud through effective deterrence, Senate Bill 279 will help patients, providers, and all Maryland taxpayers.

The Administration requests a favorable report.