

MACS CEO & Management Conference

THE TRUTH ABOUT THE FALSE CLAIMS ACT

November 28, 2018

**Presented By: Sharon Krevor-Weisbaum, Managing Partner
Brown, Goldstein & Levy, LLP**

BROWN GOLDSTEIN LEVY

**THE
TRUTH
ABOUT
THE FALSE
CLAIMS
ACT**

Don't let this happen to you!

Don't let
this
happen to
you!

BRIAN E. FROSH
ATTORNEY GENERAL



MEDIA CONTACTS:
PRESS@OAG.STATE.MD.US
410-576-7009

PRESS RELEASE

Living Lifestyle Service, Inc. to Pay \$500,000 for Services Not Rendered and Improperly Billing Medicaid

BALTIMORE, MD (January 7, 2018) – Maryland Attorney General Brian E. Frosh announced today that LivingLifestyle Service, Inc., a developmental disability administration provider based in Baltimore, will pay \$500,000 to the State of Maryland to resolve allegations that the non-profit organization billed the state Medicaid program for non-rendered services.

Living Lifestyle Service, Inc. is responsible for providing community-based housing and other supports to persons with intellectual/developmental disabilities. The investigation found that Living Lifestyle Service, Inc. failed to provide sufficient staffing to meet the needs of a under its care. Living Lifestyle Service, Inc. billed the Medicaid program and received payment for services that were not actually delivered.

“This company cheated the State by billing for services they did not provide,” said Attorney General Frosh. “More importantly, they cheated some of our most vulnerable citizens who depend upon those services. This conduct violates our law and our duty to developmentally disabled members of our community.”

In making today’s announcement, Attorney General Frosh thanked Jennifer S. Forsythe, deputy director of the Medicaid Fraud Control Unit, Assistant Attorney General Adam T. Sampson, Auditor Carol Kelly and Investigators Michael Regan and Valerie Puig for their work on the case, in addition to the Maryland Department of Health and the Developmental Disabilities Administration.

THE TRUTH ABOUT THE FALSE CLAIMS ACT

- I. Review of the FCA & Md. FCA
- II. Theories of Provider Liability
- III. Enforcement Efforts in Maryland
- IV. Ensuring Compliance and Protecting Your Company

**THE
TRUTH
ABOUT
THE FALSE
CLAIMS
ACT**

**I. Review of the FCA
& Md. FCA**

I. Review of the FCA & Md. FCA

- A. Purpose**
- B. How it Works**
- C. Potential Penalties**
- D. Critical Terms**
- E. Medicaid Context**

I. Review of the FCA & Md. FCA

A. PURPOSE

The FCA & Md. FCA impose
civil liability on:

“any person who . . . knowingly
presents, or causes to be
presented, a false or fraudulent
claim for payment or approval.”

31 U.S.C. § 3729(a)(1)(A); *see also* Md. Code Ann., Health Gen. § 2-602(a).

I. Review of the FCA & Md. FCA

A. PURPOSE

Two major takeaways

1. Created to oversee and prevent government corruption; and
2. Laws changed to reward whistleblowers.



James D. Young, *The False Claims Act*, The Whistleblower Attorneys (Nov. 7, 2016)
<https://www.whistleblowerattorneys.com/podcasts/podcast-episode-1/>.



I. Review of the FCA & Md. FCA

B. HOW IT WORKS

1. Government can initiate its own, independent investigation
2. A third-party “relator” (i.e., whistleblower) can file a civil action on the government’s behalf
 - Known as a “*qui tam*” action

31 U.S.C. § 3730(a)–(b); see also Md. Code Ann., Health Gen. § 2-604.

I. Review of the FCA & Md. FCA

B. HOW IT WORKS

Qui tam actions:

Mark Greenbaum, Attorney:

"If you're a citizen and you report fraud that's being conducted by a contractor - say, against the government - and the government takes up the case and wins it and wins an award, you get a piece of that award."



Stacey Vanek Smith, *How a Law from the Civil War Fights Modern-Day Fraud*, npr.org (Oct. 1, 2014), <https://www.npr.org/sections/money/2014/10/01/352819369/how-a-law-from-the-civil-war-fights-modern-day-fraud>.



I. Review of the FCA & Md. FCA

C. POTENTIAL PENALTIES

“(a) Liability for Certain Acts.—

(1) In general. . . .

is liable to the United States Government for a civil penalty of not less than \$5,000 and not more than \$10,000, as adjusted by the Federal Civil Penalties Inflation Adjustment Act of 1990 . . . , plus 3 times the amount of damages which the Government sustains because of the act of that person.”

I. Review of the FCA & Md. FCA

C. POTENTIAL PENALTIES

- “(1) A person who is found to have violated . . . this section is liable to the State for:
- (i) A civil penalty of not more than \$10,000 for each violation of subsection (a) of this section; and
 - (ii) An additional amount of not more than three times the amount of damages that the State sustains as a result of the acts of that person in violation of subsection (a) of this section.
- (2) The total amount owed by a person under paragraph (1) of this subsection may not be less than the amount of the actual damages the State health plan or State health program incurs as a result of the person’s violation of subsection (a) of this section.”

I. Review of the FCA & Md. FCA

C. POTENTIAL PENALTIES

**Notable differences between
calculating penalties under the
FCA and the Md. FCA**

I. Review of the FCA & Md. FCA

C. POTENTIAL PENALTIES

Under FCA, a court has narrow discretion to reduce penalties:

I. Review of the FCA & Md. FCA

C. POTENTIAL PENALTIES

"(a) Liability for Certain Acts.—

(2) Reduced damages.—If the court finds that—

- (A) the person committing the violation of this subsection furnished officials of the United States responsible for investigating false claims violations with all information known to such person about the violation within 30 days after the date on which the defendant first obtained the information;
- (B) such person fully cooperated with any Government investigation of such violation; and
- (C) at the time such person furnished the United States with the information about the violation, no criminal prosecution, civil action, or administrative action had commenced under this title with respect to such violation, and the person did not have actual knowledge of the existence of an investigation into such violation,

the court may assess not less than 2 times the amount of damages which the Government sustains because of the act of that person."

I. Review of the FCA & Md. FCA

C. POTENTIAL PENALTIES

Under the Md. FCA, a court has *much broader* discretion to reduce penalties, which includes a multi-factor analysis:

I. Review of the FCA & Md. FCA

C. POTENTIAL PENALTIES

"(1) In determining the appropriate amount of fines and damages under subsection (b) of this section, the court shall consider:

- (i) The number, nature, and severity of the violations of this subtitle for which the person has been found liable;
- (ii) The number, nature, and severity of any previous violations of this subtitle;
- (iii) The degree of loss suffered by the State health plan or State health program;
- (iv) The person's history of billing compliance;
- (v) Whether the person has a compliance program in place;
- (vi) The extent to which the person has taken steps to address and correct the violation since the person became aware of the violation;
- (vii) The extent to which the violation caused harm or detriment to patients or consumers of the State health plan or State health program;
- (viii) Any funds previously returned to the State health plan or State health program in compliance with federal requirements regarding overpayments, to the extent the funds represented losses to the State health plan or State health program caused by the violation;
- (ix) Whether the person self-reported the violation, the timeliness of the self-reporting, the extent to which the person otherwise cooperated in the investigation of the violation, and the extent to which the person had prior knowledge of an investigation or other action relating to the violation; and
- (x) Any other factor as justice requires.

(2) In weighing the factors set forth in paragraph (1) of this subsection, the court shall, where appropriate, give special consideration to:

- (i) The extent to which the person's size, operations, or financial condition may have affected each of the factors set forth in paragraph (1) of this subsection; and
- (ii) The extent to which the person's size, operations, or financial condition may affect the person's ability to provide care and continue operations after payment of damages and fines."

Md. Code Ann., Health Gen. § 2-602(c).

I. Review of the FCA & Md. FCA

D. CRITICAL TERMS

1. *False or Fraudulent*
2. *Claim*
3. *Knowing or Knowingly*
4. *Material*

*****Beware of “half-truths”**

I. Review of the FCA & Md. FCA

D. CRITICAL TERMS

5. *Overpayment*

111TH CONGRESS } LEGISLATIVE COUNSEL } PRINT 111-1
2d Session }

COMPILATION OF PATIENT PROTECTION AND AFFORDABLE CARE ACT

[As Amended Through May 1, 2010]

INCLUDING

PATIENT PROTECTION AND AFFORDABLE CARE ACT
HEALTH-RELATED PORTIONS OF THE HEALTH CARE AND
EDUCATION RECONCILIATION ACT OF 2010

PREPARED BY THE
Office of the Legislative Counsel
FOR THE USE OF THE
U.S. HOUSE OF REPRESENTATIVES



MAY 2010

“[A]ny funds that a person receives or retains from [Medicare or Medicaid] to which the person, after applicable reconciliation, is not entitled”

42 U.S.C. § 1320a-7(d)(4)(B).

I. Review of the FCA & Md. FCA

D. CRITICAL TERMS

5. Overpayment

- 60-Day Rule
- An overpayment retained after the deadline becomes an “obligation” under the False Claims Act
- Legally required to report



Hillary M. Stemple, *The Final 60 Day Overpayment Rule: Overview, Recent Developments, and What it Means for You and Your Clients*, Am. Bar Assoc. (Apr. 17, 2018), https://www.americanbar.org/content/dam/aba/administrative/healthlaw/60_day_rule_Webinar.pdf; see also 42 U.S.C. § 1320a-7k(d)(2).

I. Review of the FCA & Md. FCA

D. CRITICAL TERMS

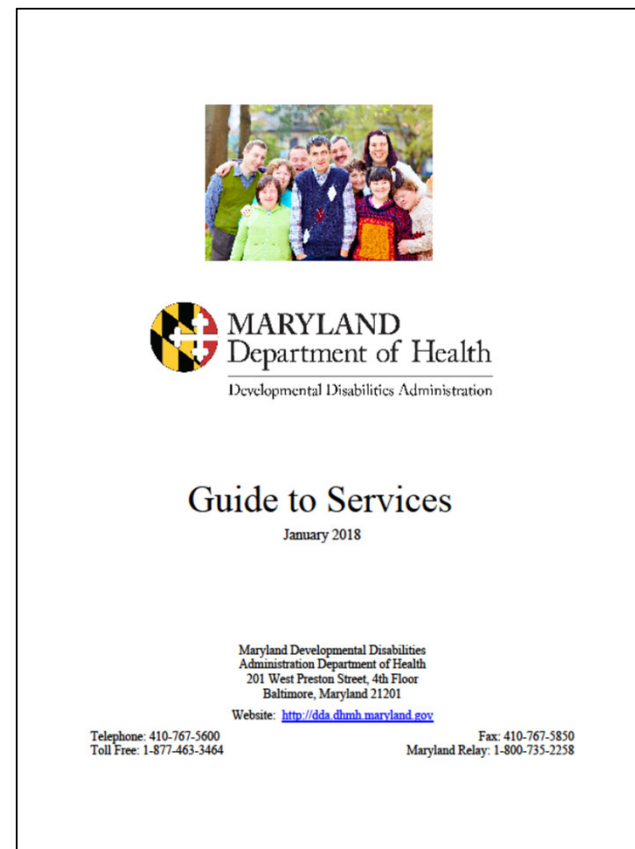
5. *Overpayment*

- Common types of overpayments:
 - errors and non-reimbursable expenditures;
 - duplicate payments;
 - payments received when another payor had the responsibility for payment; and
 - billing for services that have inadequate documentation.



I. Review of the FCA & Md. FCA

E. MEDICAID CONTEXT



Md. Dep't of Health Dev. Disabilities Admin., *Guide to Services* (Jan. 2018), available at [https://dda.health.maryland.gov/Documents/Updated%20Participant%20Guide%20to%20DDA%20Services_\(1-12-2018\).pdf](https://dda.health.maryland.gov/Documents/Updated%20Participant%20Guide%20to%20DDA%20Services_(1-12-2018).pdf).

I. Review of the FCA & Md. FCA

E. MEDICAID CONTEXT



MARYLAND
Department of Health

Developmental Disabilities Administration

MEDICAID FRAUD

Medicaid fraud is the payment of Medicaid funds for services or people who are not eligible to receive them. This can be done by the eligible person or by those providing services.

Md. Dep't of Health Dev. Disabilities Admin., *Guide to Services* 27 (Jan. 2018), available at [https://dda.health.maryland.gov/Documents/Updated%20Participant%20Guide%20to%20DDA%20Services \(1-12-2018\).pdf](https://dda.health.maryland.gov/Documents/Updated%20Participant%20Guide%20to%20DDA%20Services%20(1-12-2018).pdf).

I. Review of the FCA & Md. FCA

E. MEDICAID CONTEXT



MARYLAND
Department of Health

Developmental Disabilities Administration

What is Provider Medicaid Fraud?

When providers steal from Maryland Medicaid, they decrease the resources available to the program. When your own providers falsify information about what services they have given to you, they can decrease the benefits you actually receive.

Medicaid providers include doctors, dentists, hospitals, nursing homes, pharmacies, clinics, counselors, personal care/homemaker chore companies, and any other individual or company that is paid by the Medicaid program. It also includes family members if you choose them to provider your services.

Your providers with the Community Pathways program would include your resource coordinator and anyone you choose, or is chosen for you, to assist with your care. If a provider intentionally misrepresents the services they delivered, or the amount of time they spent performing them and are paid more by Maryland Medicaid, than they actually earned, provider fraud has occurred. If a provider bills for an assessment and says you need specific equipment that you must buy from them, provider fraud has also occurred.

Md. Dep't of Health Dev. Disabilities Admin., *Guide to Services* 27 (Jan. 2018), available at [https://dda.health.maryland.gov/Documents/Updated%20Participant%20Guide%20to%20DDA%20Services \(1-12-2018\).pdf](https://dda.health.maryland.gov/Documents/Updated%20Participant%20Guide%20to%20DDA%20Services%20(1-12-2018).pdf).

I. Review of the FCA & Md. FCA

E. MEDICAID CONTEXT



MARYLAND
Department of Health

Developmental Disabilities Administration

Examples of provider fraud:

1. Billing for any services not actually performed;
2. Billing for a more expensive service than was actually rendered;
3. Billing for several services that should be combined into one billing;
4. Billing twice for the same service;
5. Dispensing generic drugs and billing for brand-name drugs;
6. Giving or accepting something in return for medical services;
7. Bribery;
8. Billing for unnecessary services;
9. False cost reports;
10. Embezzlement of participant funds; and
11. Falsifying timesheets or signatures in connection with the provision of personal care services.

Md. Dep't of Health Dev. Disabilities Admin., *Guide to Services* 27–28 (Jan. 2018), available at [https://dda.health.maryland.gov/Documents/Updated%20Participant%20Guide%20to%20DDA%20Services \(1-12-2018\).pdf](https://dda.health.maryland.gov/Documents/Updated%20Participant%20Guide%20to%20DDA%20Services%20(1-12-2018).pdf).

I. Review of the FCA & Md. FCA

E. MEDICAID CONTEXT

Listen to this example:



James D. Young, *Types of Fraud and Whistleblower Laws*, The Whistleblower Attorneys (Nov. 7, 2016), <https://www.whistleblowerattorneys.com/podcasts/podcast-episode-1/>.



**THE
TRUTH
ABOUT
THE FALSE
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II. Theories of Provider Liability

II. Theories of Provider Liability

(Slip Opinion)

OCTOBER TERM, 2015

1

Syllabus

NOTE: Where it is feasible, a syllabus (headnote) will be released, as is being done in connection with this case, at the time the opinion is issued. The syllabus constitutes no part of the opinion of the Court but has been prepared by the Reporter of Decisions for the convenience of the reader. See *United States v. Detroit Timber & Lumber Co.*, 200 U. S. 321, 337.

SUPREME COURT OF THE UNITED STATES

Syllabus

UNIVERSAL HEALTH SERVICES, INC. *v.* UNITED STATES ET AL. EX REL. ESCOBAR ET AL.

CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIRST CIRCUIT

No. 15–7. Argued April 19, 2016—Decided June 16, 2016

- Leading Supreme Court case interpreting the FCA in the healthcare context.
- Establishes three distinct theories of liability.
- Focuses on the term “materiality.”

II. Theories of Provider Liability

SUPREME COURT OF THE UNITED STATES

Syllabus

UNIVERSAL HEALTH SERVICES, INC. v. UNITED STATES ET AL. EX REL. ESCOBAR ET AL.

Facts

- In October 2009, Yarushka Rivera died at the age of 17 from an adverse reaction to a medication she was given while being treated at a mental health facility.
- Rivera's mother, Carmen Correa, and her stepfather, Julio Escobar, later learned that of the five "professionals" treating Rivera, only one was properly licensed.

Universal Health Servs., Inc. v. United States, ex rel. Escobar, -- U.S. --, 136 S. Ct. 1989, 1996–98 (2016).

II. Theories of Provider Liability

SUPREME COURT OF THE UNITED STATES

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UNIVERSAL HEALTH SERVICES, INC. v. UNITED STATES ET AL. EX REL. ESCOBAR ET AL.

Facts

- Ms. Correa and Mr. Escobar initiated a *qui tam* action alleging that the facility had submitted false Medicaid reimbursements by misrepresenting their qualifications and licensing status.
- The United States declined to intervene in this action and Ms. Correa and Mr. Escobar prosecuted the case in their individual capacity.

Universal Health Servs., Inc. v. United States, ex rel. Escobar, -- U.S. --, 136 S. Ct. 1989, 1996–98 (2016).

II. Theories of Provider Liability

SUPREME COURT OF THE UNITED STATES

Syllabus

UNIVERSAL HEALTH SERVICES, INC. v. UNITED STATES ET AL. EX REL. ESCOBAR ET AL.

Oral arguments held on April 19, 2016:



Malcolm L. Stewart
Deputy Solicitor General
for United States
(In support of
Ms. Correa &
Mr. Escobar)

Oral Argument, *Universal Health Services, Inc. v. United States, ex rel. Escobar*,
-- U.S. --, 136 S. Ct. 1989 (2016) (No. 15-7), www.oyez.org/cases/2015/15-7.



II. Theories of Provider Liability

SUPREME COURT OF THE UNITED STATES

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UNIVERSAL HEALTH SERVICES, INC. v. UNITED
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Oral arguments held on April 19, 2016:



Roy T. Englert, Jr.
(In support of
Provider)

Oral Argument, *Universal Health Services, Inc. v. United States, ex rel. Escobar*,
-- U.S. --, 136 S. Ct. 1989 (2016) (No. 15-7), www.oyez.org/cases/2015/15-7.



II. Theories of Provider Liability

SUPREME COURT OF THE UNITED STATES

Syllabus

UNIVERSAL HEALTH SERVICES, INC. v. UNITED STATES ET AL. EX REL. ESCOBAR ET AL.

Oral arguments held on April 19, 2016:



Roy T. Englert, Jr.



Justice Sonya Sotomayor

Oral Argument, *Universal Health Services, Inc. v. United States, ex rel. Escobar*,
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II. Theories of Provider Liability

SUPREME COURT OF THE UNITED STATES

Syllabus

UNIVERSAL HEALTH SERVICES, INC. v. UNITED
STATES ET AL. EX REL. ESCOBAR ET AL.

1. *Facially False Claims*
2. *Express Certification Theory*
3. *Implied Certification Theory*

II. Theories of Provider Liability

Theory 1: *Facially False Claims*

SUPREME COURT OF THE UNITED STATES



- Justice Elena Kagan

"The government contracts to buy guns; the guns don't shoot. The government contracts to buy boots -- this was all within the context of the Civil War -- the boots fell apart after 12 hours. The government contracts to buy food; the food was rancid.

And each of those contractors would come in and would demand payment. And the entire idea behind this statute is that in that demand of payment is a representation.

The representation is that I've given you guns that shoot and boots that wear and food that can be eaten. And when -- when that is not true, that is a fraudulent claim."

Oral Argument, *Universal Health Services, Inc. v. United States, ex rel. Escobar*,
-- U.S. --, 136 S. Ct. 1989 (2016) (No. 15-7), www.oyez.org/cases/2015/15-7.



II. Theories of Provider Liability

Theory 2: *Express Certification*

SUPREME COURT OF THE UNITED STATES



- Justice Elena Kagan

"Let's say that there's a contract and there is an explicit term, and it says I commit to providing a doctor's care.

Yes? And then it turns out that the medical care that was provided was not by a doctor. It was by a nurse or it was by somebody with not even that set of qualifications.

And -- and then the person who enters into the contract makes a statement, demands payment, and says the care was provided. Now, some care was provided; it is true. But medical care, a doctor's care was not provided. Now, by withholding that fact and by just saying the care was provided, have I not committed fraud under the common law?"

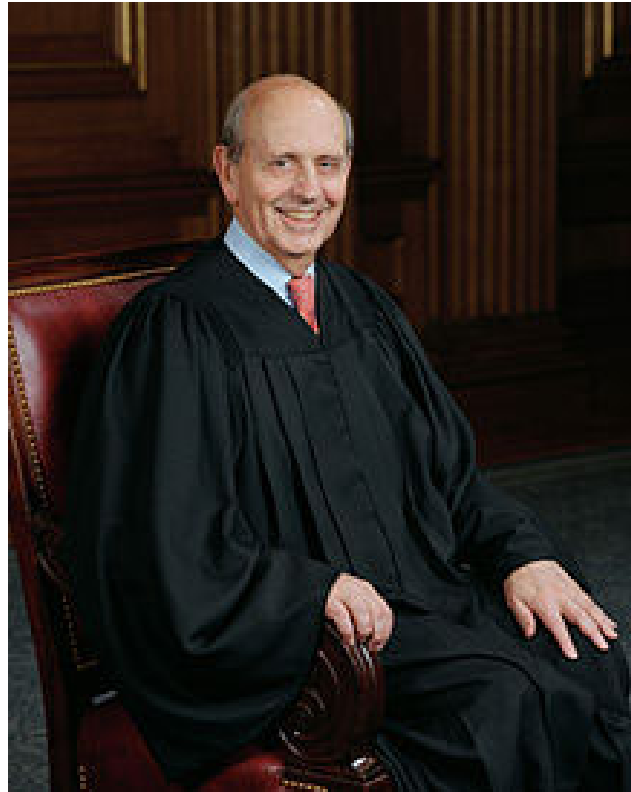
Oral Argument, *Universal Health Services, Inc. v. United States, ex rel. Escobar*,
-- U.S. --, 136 S. Ct. 1989 (2016) (No. 15-7), www.oyez.org/cases/2015/15-7.



II. Theories of Provider Liability

Theory 3: *Implied Certification*

SUPREME COURT OF THE UNITED STATES



- Justice Stephen G. Breyer

“Suppose you have a private contract. In the private contract, it's for medical services.

The written part does not actually use the word ‘doctor,’ but the circumstances are such that any reasonable person would assume, would believe that the parties contracted for medical services provided by a doctor. This is an ordinary contract case.

Could not a jury or the judge find that that implicit term of the contract that the services would be provided by a doctor was breached, it was a material breach, and, therefore, the implicit statement was false?”

Oral Argument, *Universal Health Services, Inc. v. United States, ex rel. Escobar*,
-- U.S. --, 136 S. Ct. 1989 (2016) (No. 15-7), www.oyez.org/cases/2015/15-7.



II. Theories of Provider Liability

SUPREME COURT OF THE UNITED STATES

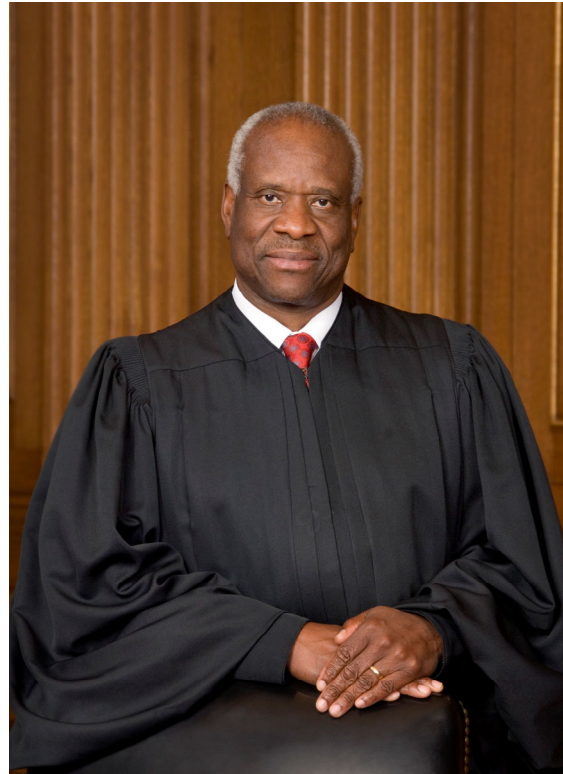
Syllabus

UNIVERSAL HEALTH SERVICES, INC. v. UNITED
STATES ET AL. EX REL. ESCOBAR ET AL.

But what is a “material breach?”

II. Theories of Provider Liability

SUPREME COURT OF THE UNITED STATES

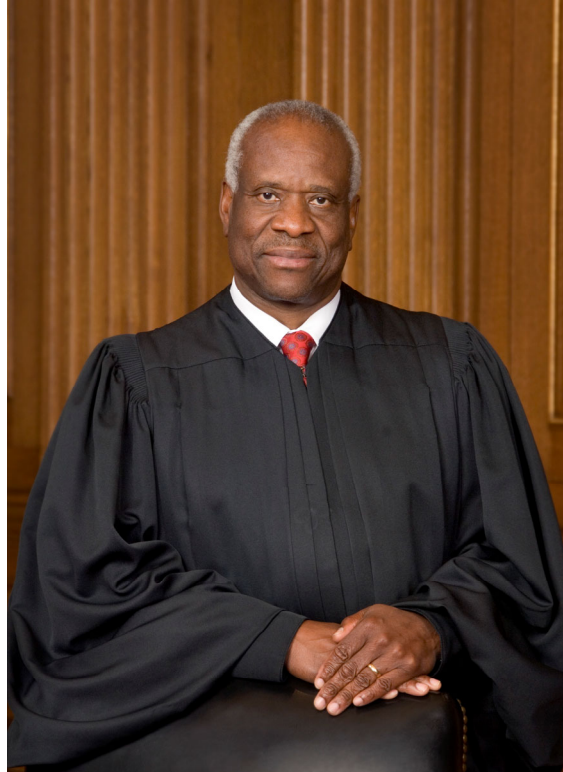


- Justice Clarence Thomas (written opinion):
- Not every violation of an express condition of payment or participation gives rise to liability.
- Condition may be relevant, but not “material.”
- A provider can have knowledge that a condition/requirement is material without the Government expressly calling it such.
- A provider under a reasonable person test may be deemed to be “deliberately indifferent” or in “reckless disregard” for its failure to appreciate the materiality of a requirement.

Universal Health Servs., Inc. v. United States, ex rel. Escobar, -- U.S. --, 136 S. Ct. 1989, 2002–04 (2016).

II. Theories of Provider Liability

SUPREME COURT OF THE UNITED STATES



- Justice Clarence Thomas (written opinion):
- If a provider knows that the Government does not pay claims where certain violations exist, such can be proof of materiality.
- Where Government regularly pays a claim despite its actual knowledge that certain requirements are not met, strong evidence that requirements are not material.
- Must prove that the same violations were presented to the same Government players in the past and those Government players still approved payment.

Universal Health Servs., Inc. v. United States, ex rel. Escobar, -- U.S. --, 136 S. Ct. 1989, 2002–04 (2016).

SUPREME COURT OF THE UNITED STATES

**II. Theories
of
Provider
Liability**

Million Dollar Question:

Would the government have paid a claim had it known of the violation?

II. Theories of Provider Liability

SUPREME COURT OF THE UNITED STATES

Syllabus

UNIVERSAL HEALTH SERVICES, INC. v. UNITED STATES ET AL. EX REL. ESCOBAR ET AL.

Makes total sense, right???



Justice Sonia Sotomayor

"I'm sorry. I'm totally confused."

Oral Argument, *Universal Health Services, Inc. v. United States, ex rel. Escobar*,
-- U.S. --, 136 S. Ct. 1989 (2016) (No. 15-7), www.oyez.org/cases/2015/15-7.



II. Theories of Provider Liability

“Real Life” Hypotheticals

II. Theories of Provider Liability

Hypothetical #1

- Maggie Kent is in need of a surgical procedure.
- Dr. Dorian knows that Ms. Kent does not have insurance.
- He learns that his former patient, Mr. Rubinowicz, recently passed away.
- Dr. Dorian and other providers at Sacred Heart Hospital devise a plan to have the deceased Mr. Rubinowicz's insurance pay for Ms. Kent's procedure.

Hypothetical #1

II. Theories of Provider Liability



Scrubs (NBC television broadcast Oct. 23, 2001), available at <https://www.youtube.com/watch?v=hsPZsn7RVA>.

Hypothetical #1

II. Theories of Provider Liability

False claim or not???

II. Theories of Provider Liability

Hypothetical #2

- Lilly is being treated for Leukemia at Chastain Park memorial Hospital.
- Her treating physician, Dr. Hunter, has submitted a claim wherein she expressly certified that all of the treatment Lilly has received is necessary.
- Dr. Nevin suspects that Dr. Hunter is overtreating Lilly, and that Lilly is receiving higher than necessary chemo protocols.
- Dr. Nevin confides in her colleague, Dr. Paresh.

Hypothetical #2

II. Theories of Provider Liability



The Resident (FOX television broadcast Mar. 1, 2018),
available at https://www.youtube.com/watch?time_continue=2&v=olCkZKjj2FY.

Hypothetical #2

II. Theories of Provider Liability

False claim or not???

II. Theories of Provider Liability

Hypothetical #3

- Dr. House is a Medicaid provider.
- His contract with the government requires that he treat patients using the “best possible bedside manner.”
- Once a month, he treats patients in an STD clinic.
- Nurse Wissle believes Dr. House has a pattern of treating patients poorly.
- She has recorded the following videos on her cell phone and intends to show these videos to Human Resources.

Hypothetical #3

II. Theories of Provider Liability



House (FOX television broadcast Jan. 30, 2007),
available at https://www.youtube.com/watch?v=E1ZN_GJqnLY.

II. Theories of Provider Liability

Hypothetical #3

False claim or not???

II. Theories of Provider Liability

Hypothetical #3

- Has Dr. House failed to comply with a contract requirement?
 - Probably.
- Was the “best possible bedside manner” requirement in the contract material?
 - Maybe/maybe not.
- Has Dr. House filed a false claim?
 - Probably not.

II. Theories of Provider Liability

Medicaid Hypotheticals

- Fire escape policy
- Criminal background check policy
- Staff ratios
- Awake overnight requirement
- Nursing assessment

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III. Enforcement Efforts in Maryland

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Don't let this happen to you!

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PRESS RELEASE

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In making today’s announcement, Attorney General Frosh thanked Jennifer S. Forsythe, deputy director of the Medicaid Fraud Control Unit, Assistant Attorney General Adam T. Sampson, Auditor Carol Kelly and Investigators Michael Regan and Valerie Puig for their work on the case, in addition to the Maryland Department of Health and the Developmental Disabilities Administration.

III. Enforcement Efforts in Maryland



Department of Health

REQUEST FOR PROPOSALS (RFP)

SOLICITATION NO. 19-18064

Issue Date: May 3, 2018

MEDICAID HOSPITAL CLAIMS AUDIT CONTRACTOR

NOTICE

A Prospective Offeror that has received this document from the Maryland Department of Health's website <https://health.maryland.gov/procumnt/Pages/Procopps.aspx>, the eMaryland Marketplace (see Section 4.2) web site <https://emarylandmarketplace.com/bid/>, or a source other than the Procurement Officer, and that wishes to assure receipt of any changes or additional materials related to this RFP should immediately contact the Procurement Officer and provide the Prospective Offeror's name and mailing address so that addenda to the RFP or other communications can be sent to the Prospective Offeror.

Minority Business Enterprises Are Encouraged to Respond to this Solicitation

Md. Dep't of Health, *Request for Proposals (RFP) Solicitation No. 19-18064, Medicaid Hospital Claims Audit Contractor* (May 3, 2018), <https://health.maryland.gov/procumnt/Documents/OIG%20-%20Medicaid%20Hosp%20Audit.Final.pdf>.



Department of Health

REQUEST FOR PROPOSALS (RFP)

SOLICITATION NO. 19-18064

III. Enforcement Efforts in Maryland

2.3.3 Contractor Objectives

The goal of the Contractor is to identify instances of Improper Payments made to Medicaid Providers by the Department in order to maximize successful recoveries, deter Provider billing errors and prevent fraud, waste, and abuse in the Maryland Medicaid program. Additionally, the Contractor will identify vulnerabilities within the Maryland Medicaid system that will help prevent future Improper Payments from occurring by suggesting improvements. Within 30 calendar days, after the submission of the approved work plan, the Contractor shall provide, as a deliverable, a detailed description outlining how these objectives will be accomplished.

Md. Dep't of Health, *Request for Proposals (RFP) Solicitation No. 19-18064, Medicaid Hospital Claims Audit Contractor* (May 3, 2018), <https://health.maryland.gov/procumnt/Documents/OIG%20-%20Medicaid%20Hosp%20Audit.Final.pdf>.

III. Enforcement Efforts in Maryland

DDA Presentation to MACS in September 2018



"The DDA has created a draft manual that will be issued by the regional offices and stakeholder to better understand and navigate the services, authorization, *and billing documentation requirements.*"

III. Enforcement Efforts in Maryland

**MARYLAND MEDICAID
CMS-1500
PAPER
BILLING INSTRUCTIONS**

*A Comprehensive Guide Focusing on Maryland
Medicaid Billing Procedures and Other Useful
Information*

Effective August 10, 2017:
Only ICD-10-CM codes for claims with dates of service
on or after October 1, 2015 can be reported.

Dept. of Health and Mental Hygiene
Office of Systems, Operations & Pharmacy
Medical Care Programs

Revised 9/2015

Md. Dep't of Health, *Maryland Medicaid CMS-1500 Paper Billing Instructions* (Aug. 10, 2017), available at <https://mmcp.health.maryland.gov/Documents/CMS1500%20Billing%20Instructions%20Update%20August%202017.pdf>.

III. Enforcement Efforts in Maryland

MARYLAND MEDICAID CMS-1500 PAPER BILLING INSTRUCTIONS

*A Comprehensive Guide Focusing on Maryland
Medicaid Billing Procedures and Other Useful
Information*

Sanctions Against Providers – General

If the Program determines that a provider, any agent or employee of the provider or any person with an ownership interest in the provider or related party of the provider has failed to comply with applicable federal or State laws or regulations, the Program may initiate one or more of the following actions against the responsible party:

1. Suspension from the Program
2. Withholding of payment by the Program
3. Removal from the Program
4. Disqualification from future participation in the Program, either as a provider or as a person providing services for which Program payment will be claimed
5. Referral to the Medicaid Fraud Control Unit for investigation and possible prosecution. The Medical Assistance Program will give reasonable written notice of its intention to impose any of the previously noted sanctions against a provider. The notice will state the effective date and the reasons for the action and will advise the provider of any right to appeal.

Md. Dep't of Health, *Maryland Medicaid CMS-1500 Paper Billing Instructions* (Aug. 10, 2017), available at <https://mmcp.health.maryland.gov/Documents/CMS1500%20Billing%20Instructions%20Update%20August%202017.pdf>.

**THE
TRUTH
ABOUT
THE FALSE
CLAIMS
ACT**

**IV. Ensuring Compliance
and Protecting Your
Company**

VI. Ensuring Compliance and Protecting Your Company

- A. Three Ways to Ensure Compliance**
- B. Three Ways to Protect Your Company if You Identify Questionable Billing**

VI. Ensuring Compliance and Protecting Your Company

A. How to Ensure Compliance

1. Federal law mandates that Medicaid providers train their employees (including management) on the FCA and state-equivalent laws.

I. Review of
the FCA &
Md. FCA

D. Medicaid
Context

A. How to Ensure Compliance

§ 1396a. State plans for medical assistance

(a) Contents

A State plan for medical assistance must—

I. Review of the FCA & Md. FCA

D. Medicaid Context

A. How to Ensure Compliance

(68) provide that any entity that receives or makes annual payments under the State plan of at least \$5,000,000, as a condition of receiving such payments, shall—

(A) establish written policies for all employees of the entity (including management), and of any contractor or agent of the entity, that provide detailed information about the False Claims Act established under sections 3729 through 3733 of title 31, administrative remedies for false claims and statements established under chapter 38 of title 31, any State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs (as defined in section 1320a-7b(f) of this title);

42 U.S.C. § 1396a(a)(68).

I. Review of the FCA & Md. FCA

D. Medicaid Context

A. How to Ensure Compliance

(B) include as part of such written policies, detailed provisions regarding the entity's policies and procedures for detecting and preventing fraud, waste, and abuse; and

42 U.S.C. § 1396a(a)(68).

I. Review of the FCA & Md. FCA

D. Medicaid Context

A. How to Ensure Compliance

(C) include in any employee handbook for the entity, a specific discussion of the laws described in subparagraph (A), the rights of employees to be protected as whistleblowers, and the entity's policies and procedures for detecting and preventing fraud, waste, and abuse;

42 U.S.C. § 1396a(a)(68).

VI. Ensuring Compliance and Protecting Your Company

A. How to Ensure Compliance

2. Keep a lookout for problematic billing under each theory of liability established by the Supreme Court in *Escobar*.

SUPREME COURT OF THE UNITED STATES

Syllabus

UNIVERSAL HEALTH SERVICES, INC. v. UNITED STATES ET AL. EX REL. ESCOBAR ET AL.



VI. Ensuring Compliance and Protecting Your Company

A. How to Ensure Compliance

- 3. Establish a compliance program.**

VI. Ensuring Compliance and Protecting Your Company

A. How to Ensure Compliance



U.S. Dep't of Health & Human Servs. Off. of Inspector Gen., *Compliance Guidance* (last updated Sept. 30, 2008), <https://oig.hhs.gov/compliance/compliance-guidance/index.asp>.

VI. Ensuring Compliance and Protecting Your Company

A. How to Ensure Compliance

U.S. OIG Seven Components:

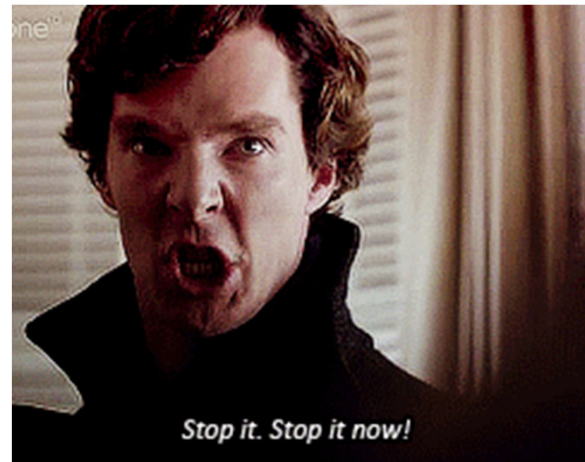
1. Conduct internal monitoring and auditing;
2. Implement compliance practices in written protocols;
3. Designate a compliance officer;
4. Conduct appropriate training and education;
5. Respond appropriately to detected offenses;
6. Develop open lines of communication with staff; and
7. Enforce disciplinary standards through well-established guidelines.

U.S. Dep't of Health & Human Servs. Off. of Inspector Gen., *Compliance Guidance* (last updated Sept. 30, 2008), <https://oig.hhs.gov/compliance/compliance-guidance/index.asp>.

VI. Ensuring Compliance and Protecting Your Company

B. How to Protect Your Company

1. Immediately cease all problematic billing practices.



VI. Ensuring Compliance and Protecting Your Company

B. How to Protect Your Company

2. Retain outside counsel.

- Why?:



James D. Young, *How to Blow the Whistle*, The Whistleblower Attorneys (Nov. 7, 2016)
<https://www.whistleblowerattorneys.com/podcasts/episode-2/>.

VI. Ensuring Compliance and Protecting Your Company

B. How to Protect Your Company

2. Retain outside counsel.

- Ensures an objective review of the facts.
- Will help to establish a comprehensive investigation plan (including preservation notices).
- Materials created in investigation are covered under attorney-client privileged or work product.

VI. Ensuring Compliance and Protecting Your Company

B. How to Protect Your Company

3. Implement corrective action

- Consider factors discussed earlier that courts consider under Maryland law.
 - Md. Code Ann., Health General § 2-602(c).
- May include self-reporting and returning overpayments.

Questions?

