# Maryland Department of Health Corporate Compliance Program 508 Accessible Version

## The Office of the Inspector General

The mission of the Office of the Inspector General is to promote integrity and accountability within the Maryland Department of Health; to deter, detect and investigate fraud, waste, abuse and employee misconduct; and to disseminate actionable and meaningful recommendations with the goal of protecting the interests of the State and its resources.

The Office of the Inspector General (OIG) is an independent unit within the Maryland Department of Health made up of auditors, investigators, compliance officers, data analysts and career professionals dedicated to its mission and serving all Marylanders.

## Corporate Compliance Program

The Maryland Department of Health (MDH) is committed to maintaining an effective compliance program in accordance with the Compliance Program Guidance published by the U.S. Department of Health and Human Services Office of the Inspector General (HHS-OIG). The MDH Corporate Compliance Program (CCP) has been designed to help prevent and detect violations of and compliance with applicable federal and state laws.

The CCP was established to create a culture that emphasizes honest and ethical behavior by every employee in the organization; Maintain compliance with applicable federal and state laws, regulations and legislation; Effectively manage the department's resources and risk; and insure accountability of all persons within the organization.

## The Division of Corporate Compliance

The MDH Corporate Compliance Program consists of: 1) the Inspector General of the MDH who reports to the Secretary of MDH; 2) the Chief Compliance Officer, who reports to the MDH Inspector General on the progress of the program and its efforts; and 3) the MDH Corporate Compliance Committee, which assists and advises the Chief Compliance Officer on healthcare compliance standards and the MDH Code of Conduct.

The Division of Corporate Compliance within the Office of the Inspector General is responsible for administering this program.

The Division of Corporate Compliance is here to help with Educating and training personnel on their legal and ethical obligations under Federal and State laws. Investigating allegations concerning suspected unethical or improper activities by members of the MDH workforce or its contractors. Providing guidance for program and institution directors and local health officers on issues relating to compliance. Establishing resources for reporting fraud, waste, or abuse in the Department, which encourages employees to file complaints without fear of retaliation.

## Health Care Law

### Medicaid

Originated as a means of ensuring healthcare coverage and services for low income and financially needy people.

Administered by the states; jointly funded by both federal and state governments.
Each state's Medicaid program reimburses providers directly for services provided to Medicaid beneficiaries from funds received from the federal government.

The Maryland Department of Health investigates Medicaid provider and recipient fraud, while the Maryland Office of the Attorney General Medicaid Fraud Control Unit prosecutes Medicaid fraud and abuse cases.

## Medicare

Established in 1965, (Title XVII of the Social Security Act) Medicare is a federally funded health insurance program for citizens 65 years or older; persons who have a long-term disability; as well as persons who have end stage renal disease as defined by the Social Security Act.

The Office of Investigations for the United States Department of Health and Human Services Office of Inspector General (HHS/OIG) collaboratively works with the Federal Bureau of Investigation (FBI) in order to combat Medicare Fraud. Defendants convicted of Medicare fraud face stiff penalties according to the Federal Sentencing Guidelines and disbarment from HHS programs.

## Anti Kickback Statute (AKB)

The Law Defined:  Title 42 of the United States Code (USC) Section 1320a-7b

The statute makes it a criminal offense to "knowingly and willfully offer, pay, solicit or receive any remuneration to induce or reward referrals of items or services reimbursable by a federal health care program such as Medicare or Medicaid. Remuneration is not limited to cash payments for referrals.

Key Elements:
A. If anything of value is exchanged:  such as referral fees, payment of travel and/or conference expenses, tickets to sporting events, free or below market value rental space between a referral source (e.g., physician) and a party who provides items or services covered by Medicaid or Medicare, then the AKB is implicated.
B. So, who's on first base in dealing with violators of the AKB?:
1. The DOJ prosecutes "criminal" AKB cases.
2. The OIG has civil authority to exclude from Medicare and Medicaid programs a provider who has participated in a kickback scheme but has not been convicted under the criminal AKB statute.

## Civil Monetary Penalty Law

The Law Defined:  Civil Monetary Penalty Law (CMPL) Title 42 of the United States Code (USC) Section 1320a-7a
The CMPL allows the DHHS OIG to impose monetary fines and assessments for a number of

unacceptable practices, e.g.:
1. Submitting False Claims
2. Accepting Kick-Backs
3. Offering or providing inducements to Medicare and Medicaid beneficiaries to influence their choice of a  Medicare or Medicaid provider.

Key Elements:
A. The OIG is authorized to seek different amounts of CMPs as well as assessments according to the type of violation. For example, in a violation of the FCA, the civil penalty may go anywhere from:
1. $5,500 to as high as $11,000 for each item or service improperly claimed.
2. And the assessment - up to three times the amount improperly claimed
B. In a violation of the AKB law, the:
1. The OIG may seek a penalty of up to $50,000 for each improper act; and an assessment up to three times the amount of remuneration;
2. Administrative remedies can include
a. Exclusion from federal and state health care programs; or
b. Government imposed compliance program.

## Civil False Claims Act

The Law Defined:  Civil False Claims Act (FCA) - Title 31 of the United States Code (USC) Sections 3729 – 3733

Signed by President Lincoln in 1863, the civil FCA makes it illegal to present (or cause to be presented) a claim to the federal government for payment or for approval when the person or entity submitting the claim "knows" that the claim is either:
a. False
b. Fraudulent; or
c. Acts in reckless disregard as to the truth or falsity of the claim, record or statement.

Key Elements:
1. Provides sanctions for anyone submitting a False; or fraudulent claim to the federal government; or
2. Uses false records or statements to obtain payment from the federal government for a false or fraudulent claim.
3. Violators are liable to the federal government and subject t o a " civil" penalty of $5,500 - $11,000 per claim, plus three time the amount of damages that the federal government sustains because of the act of that person.
4. In addition to civil penalties provided for in the FCA, violators are subject to additional penalties imposed by the OIG of DHHS to include:
a. Civil monetary penalties
b. Prospective exclusion from participation in all federal and state health care programs

## Whistleblower (Qui Tam) Provisions

A. Under the FCA, a private person known as a "Qui Tam Relater" or Whistle Blower may:
1. Bring a suit on behalf of the Federal Government to recover federal funds used to pay false or fraudulent claims
B. If the government proceeds with the case initiated by the Qui Tam Relater and is successful in winning, the Relater gets 15°/o - 25°/o of the proceeds
C. If the government declines the case and the Relater wins or settles on his her own, he/she is entitled to 25°/o - 30°/o of the proceeds plus reasonable costs and attorney fees.
D. Protections for the Whistleblower
1. Protected from being discharged from their place of employment;
2. Demoted;
3. Suspended;
4. Threatened;
5. Harassed; or
6. Discriminated against in terms of conditions of employment by their employer for being a Whistle Blower

## HIPAA

The Law Defined: HIPAA's intent is to reform the health care industry by:
1. Reducing costs;
2. Simplifying administrative processes and burdens; and
3. Improving the privacy and security of patients' information

The Purpose of HIPAA
1. To amend the Internal Revenue Code of 1986 to improve portability and continuity of health insurance coverage in the group and individual markets.
2. Combat waste, fraud, and abuse in health insurance and health care delivery
3. Promote the use of medical savings accounts,
4. Improve access to long-term care services and coverage,
5. Simplify the administration of health insurance, and for other purposes.

## Physician Self Referral Act

The Law Defined: Physician Self Referral Act (Stark Self Referral Law) also known as (The Stark Law) Title 42 of the United States Code (USC) Section 1395nn

Key Elements:
A. Enacted in 1995, the Stark legislation was sponsored by Congressman Pete Stark of California in 1989
B. It prohibit s a physician from referring Medicare and Medicaid patients for certain Designated Health Services (DHS) to entities in which:
1. the physician; or
2. their Immediate family member has a financial relationship unless an applicable except ion applies
C. It also prohibits the Designated Health Services (DHS) provider from billing for any services rendered or goods delivered because of a prohibited referral

D. It ensures the physician's decision to refer is based on the best interest of the patient and not the physician's financial interest in the entity that provides the service or goods.
The definition for DHS is found in the Code of Federal Regulations (CFR) Title 42 Section 411.351

Designated Health Services include:
a. Clinical lab services;
b. Physical therapy;
c. Occupational therapy and speech pathology;
d. Radiology and certain other imaging services;
e. Radiation therapy and supplies;
f. Durable Medical Equipment (DME) and supplies;
g. Parenteral and enteral nutrients, equipment and supplies;
h. Prosthetics, orthotics and prosthetic devices and supplies;
i. Home health services;
j. Outpatient Rx drugs; and
k. Inpatient and outpatient hospital services.

## Intentions

The Stark Law is intended to eliminate:
a. Conflicts of Interest given the physician's position to benefit from self referrals
b. Over-utilization of services driving up health care costs through self referrals
c. The creation of a captive referral system which limits competition by other providers
The penalties include:
1. Denial of payment for services resulting from a prohibited referral;
2. Refund of any payment made by the CMS to an entity furnishing DHS as a result of a prohibited referral;
3. A CMP of up to $15,000 per service plus an assessment of not more than three times the amount claimed
4. A CMP of up to $100,000 for circumvention schemes
5. A CMP of not more than $10,000 per day for failure to comply certain reporting requirements
6. Program exclusion
7. Potential prosecution under the FCA

## Violations

Potential Violations of Stark Law, or "What to look for" include:
1. Is there a financial relationship between the physician (or immediate family member) and the entity providing the OHS services?
2. If yes, does the physician make referrals to the entity for OHS?
3. If yes, are t he services payable or paid by Medicare or Medica id?
4. If yes, do any of the Stark statutory exceptions apply (See CFR Title 42, section 411 .355 - 357)
5. If yes, does the arrangement meet all of the qualifications of the applicable exception?
For more information on the Stark Law you can visit the CMS website at www.ems.hhs.gov

## Deficit Reduction Act

Key Elements:
A. On February 8, 2006, President George W. Bush signed into law the Deficit Reduction Act of 2005 (ORA)
B. The ORA, Section 6032 mandates that certain entities (e.g., States) participating in Medicaid programs inform their employees, contractors and agents about the details of state and federal false claim statutes and whistle blower protections.
C. Jan. 1, 2007 was the deadline for states' compliance with section 6032 of the ORA
D. Section 6032 entitled "Employee Education About False Claims Recovery" requires entities (e.g., MDH), who either receive or make $5 million in annual Medicaid payments, to establish specific written policies for all of their employees, and any contractors and agents.
E. The entity's written policies must include information about:

1. The federal FCA
2. Remedies for false claims and statements
3. Any state laws pertaining to civil or criminal penalties for false claims and statements
4. The Whistle Blower protections under the federal FCA and state laws
5. The role of such laws in preventing and detecting fraud, waste and abuse in federal healthcare programs.
6. The entity's (MDH) policies and procedures for detecting and preventing fraud, waste and abuse (i.e., the MDH Corporate Compliance Program)
7. Wherein any Employee Handbook of the entity (MDH), a specific discussion of:

a. State and federal laws;
b. The rights of employees to be protected as " Whistle Blowers";
c. The entity's policies for detecting fraud waste and abuse
F. Pertaining to state laws, civil or criminal penalties for false claims and statements, MDH policy includes the following language:

Under the Maryland Medicaid Fraud statute (see Md. Code Ann., Criminal Law §§ 8-508 to 8-517), a person who knowingly and willfully:
1. defrauds or attempts to defraud a State health plan in connect ion with the delivery of or payment for a health care service, or
2. obtains or attempts to obtain by means of a false representation anything of value in connection with the delivery of or payment for a health care service through a State health plan, is guilty of a crime and is subject to imprisonment, a fine, or both; and is liable to the state for a civil penalty of up to three times the amount of the overpayment.

## Federal and State Agencies

The following Federal and State agencies are involved in combating healthcare fraud:
United States Department of Health and Human Services Office of the Inspector General
United States Department of Health and Human Services Office of Civil Rights
United States Department of Justice

Maryland Office of the Attorney General Medicaid Fraud Control Unit
Maryland Department of Health Office of the Inspector General

## Code of Conduct

Employees Responsibilities:
While carrying out the Department's mission, all employees are expected to conduct the Department's business in a consistent and professional manner, adhering to the following principles:

Perform all activities in compliance with pertinent laws and regulations, including those applying to fraud and abuse, false claims, self-referral prohibitions, anti-trust, employment discrimination, environmental protection, lobbying and political activity, and the Maryland Public Ethics Law
While carrying out the Department's mission, all employees are expected to conduct the Department's business in a consistent and professional manner, adhering to the following principles:

Perform all activities in compliance with pertinent laws and regulations, including those applying to fraud and abuse, false claims, self-referral prohibitions, anti-trust, employment discrimination, environmental protection, lobbying and political activity, and the Maryland Public Ethics Law.
Participate in and promote high standards of business ethics and integrity. Maryland Department of Health employees must not engage in any activity intended to defraud anyone of money, property or services.

Perform all duties accurately and honestly.
Maintain appropriate levels of confidentiality as it relates to the public and other Maryland Department of Health employees by protecting personal information and referring inquiries to designated officials.

Conduct business transactions with suppliers, vendors, contractors and other third parties free from offers or solicitations of gifts and favors, or other improper inducements.

Avoid conflicts of interest, in appearance or fact, in the conduct of all activities. In the event that there are conflicts, Maryland Department of Health employees must take prompt, appropriate action to make full disclosure to the appropriate authorities.

Preserve and protect the Department's assets by making prudent and effective use of resources, property, and accurate financial reporting.

Refrain from presenting or causing to be presented, any claim or billing for services not provided, or that the individual knows to be false or fraudulent.

## In Conclusion

All Maryland Department of Health (MDH) employees have an obligation to report to the Office of the Inspector General any incidents of suspected fraud, waste, abuse, or misconduct occurring within MDH that violate any laws, MDH policies, or the Code of Conduct.
Fraud, waste and abuse reports may be made anonymously orally or in writing. Call 1-866-770-

7175 or visit the Office of the General's website http://health.maryland.gov/oig or email dhmh.oig@maryland.gov.

For more information on the MDH Corporate Compliance Program or to make a report of fraud, waste, abuse, or misconduct to the OIG, please contact:
Sha S. Brown, MDH Chief Compliance Officer at email address: sha.brown1@maryland.gov or call 410-767-5228.