

Editor's note: The area of fraud and abuse in health care has received a great deal of attention from federal and state regulators during the past few years. This is a growing area of legal practice. The author of this article presents a summary of the state law remedies for Medicaid fraud and abuse in Michigan.

BY MICHAEL FRALEIGH

State

The Department of Community Health (DCH) administers Michigan's Medicaid program (Medicaid). The terms and conditions of a provider's participation in Medicaid is governed by the Social Welfare Act, MCL 400.1 et seq., the provider's contract with Medicaid, and by Medicaid's provider manuals.

By submitting claims to Medicaid, a provider is certifying to Medicaid that the claims are true and accurate; prepared with the provider's knowledge and consent; do not contain any untrue, misleading, or deceptive information; and comply with Medicaid's policies, procedures, and guidelines. In light of this, Michigan courts have held that:¹

- The failure to bill in accordance with Medicaid guidelines may constitute a false claim.
- Deviation from the Medicaid procedures are presumed to be intentional or provide evidence that the provider knew the claims were false.
- Providers have an affirmative duty to check the accuracy of their claims to avoid mistakes.

In addition, providers have an affirmative duty to promptly notify Medicaid when they receive a payment they are not entitled to or that exceeds the amount they were entitled to receive.² The failure to return the "overpayment" to Medicaid constitutes conversion. When a payment is challenged, the provider must be able to prove that it was entitled to the money it received from Medicaid.³ Any payment the provider cannot substantiate is an overpayment and may be considered a false claim.

Cases of Medicaid fraud or abuse⁴ (fraud) may involve thousands of individual claims. An actual audit of each claim is far too costly and time consuming to be practical. Accordingly, DCH relies on statistically valid random sample audits to establish the total amount of overpayments received by a provider. The courts accept the audits as evidence of Medicaid's losses.⁵ An audit may be challenged or rebutted on the basis that it is not statistically valid, was not random, or it contains mathematical or other errors.

Remedies for Medicaid fraud include administrative actions, civil suits, and criminal prosecutions. The remedies are not mutually exclusive. When appropriate, they are used

in conjunction with each other to meet the state's needs in a particular case.

To analyze the potential for liability for Medicaid fraud, it is important to understand the following terms.⁶

- **Benefit:** money, goods, or anything of pecuniary value
- **Claim:** any attempt to cause DCH to pay money under the Medicaid program
- **Deceptive:** a statement of fact or a failure to reveal a material fact that leads DCH to believe the represented or suggested facts are different than they actually are
- **False:** wholly or partially untrue or deceptive
- **Knowing and knowingly:** a person possesses facts under which he or she is aware or should be aware that his or her conduct is substantially certain to cause the payment of a Medicaid benefit
- **Person:** an individual, corporation, association, partnership, or other legal entity

Criminal Prosecutions

The criminal charges for Medicaid fraud are not limited to the Michigan Medicaid

An overview of state criminal, civil, and

Response

to Medicaid Fraud and Abuse

False Claims Act (MFCA), codified at MCL 400.601–MCL 400.613. Charges against a provider may be based on any criminal statute that is violated by a person that defrauds Medicaid. This includes falsification of a medical record,⁷ obstruction of justice,⁸ money laundering,⁹ criminal enterprise,¹⁰ and computer fraud.¹¹ It also includes conspiracy, accessory, aiding and abetting, and attempts of any crime committed during the submission of false claims.

Prosecutions are not limited to the individuals directly involved in the fraud. Consultants, accountants, attorneys, and other persons indirectly involved in the fraud may also be prosecuted.

False claims are often brought under the MFCA. The most frequently used section of the MFCA is MCL 400.607(1). This section of the act requires proof that the accused, knowingly made, presented, or caused a false claim to be made or presented to Medicaid. An error or mistake will not support a false claim charge unless the person's course of conduct indicates a systemic or persistent tendency to cause inaccuracies in the claims submitted to Medicaid. In such a case, the person is considered to have knowledge of

and to have intended the submission of the false claims.

The penalty for violation of MCL 400.607(1) is imprisonment for up to four years and/or a fine of up to \$50,000.

Medicaid providers are required to provide goods and services that are medically necessary as defined by professionally accepted standard of care. It is a felony to submit a claim to Medicaid for providing goods or services that are not medically necessary.¹² The felony is punishable by imprisonment for up to four years and/or a fine of not more than \$50,000.

MCL 400.607(2) of the MFCA applies primarily to health care providers other than health facilities or agencies. A health facility or agency is not liable under this section unless it acted in concert with a physician or other provider to falsely represent the medical necessity of the goods or services provided to a Medicaid recipient.

The MFCA, MCL 400.604, prohibits soliciting, offering, or accepting a bribe or kickback for furnishing goods or services or referring patients for goods or services.¹³ The bribe or kickback may be anything of value, including money, reduced rent, services,

goods or rebate on the provider's fee, or the patient's copayment. A violation of this section is a felony punishable by up to four years imprisonment and/or a fine of up to \$30,000.

Hospitals, skilled nursing facilities, intermediate nursing facilities, and home health agencies are required to obtain certification prior to Medicaid participation. If a facility fails to maintain its certification, it cannot participate in the Medicaid program. In order to safeguard Medicaid recipients, the legislature has made it a felony to make a false statement or representation of material fact regarding the conditions in or operation of a facility in order to obtain or maintain the required certification.¹⁴ A violation of this section may be punished by imprisonment for up to four years and/or a fine of up to \$30,000.

Courts are required to order restitution based on the defendant's "course of conduct."¹⁵ Accordingly, the actual dollar value of the specific Medicaid fraud counts charged in the criminal complaint is irrelevant in determining the amount of restitution to be ordered by the court.¹⁶ The defendant is required to fully repay all of the money illegally

administrative remedies

The points of view and opinions stated in this article are those of the author and may not represent the official position of Jennifer M. Granholm, attorney general of the state of Michigan.

received from Medicaid by the course of conduct described in the criminal complaint.

An order of restitution is a judgment and lien on *all* of the assets of the defendant.¹⁷ If the defendant is financially able to do so, the restitution order must be paid immediately.¹⁸ The law does not allow the defendant to keep vacation property, retirement accounts, investments, luxury vehicles, or other assets that may be used to pay restitution. Accordingly, a detailed and thorough review of the defendant's assets is required. After inventorying the defendant's assets, the court should order the liquidation of the assets necessary to pay the restitution.

Civil Remedies

A Medicaid provider is contractually and statutorily obligated to provide care to Medicaid recipients, consistent with state and federal statutes, rules, and guidelines. A provider breaches its contract with Medicaid when it fails to provide the required level of care or comply with the conditions of Medicaid participation. Accordingly, the state may recover on a contract theory, such as breach of contract or unjust enrichment, for the submission of false claims and/or the failure to provide the required services.

The MFCA requires the court to award the state a civil penalty against any person who through fraud, making a fraudulent statement, or knowingly concealing a material fact, receives Medicaid money that the person is not entitled to receive.¹⁹ The civil penalty is required to be imposed as the result of a civil suit or criminal prosecution and is equal to:

- the total amount of the false claim; plus
- three times the damages suffered by the state

The damages equal the sum of the Medicaid overpayment,²⁰ plus lost interest, investigative costs, audit costs, and costs of litigation, including attorney fees.

State Administrative Sanctions

The Director of DCH (director) has the authority to impose administrative sanctions on providers that voluntarily participate in Medicaid.

Fast Facts

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If a facility fails to maintain its certification, it cannot participate in the Medicaid program.

The director may issue an emergency order to protect the public health, safety, or welfare; Medicaid recipients; or Medicaid funds. Circumstances that warrant emergency action by DCH include, a reasonable belief that:²¹

- The provider has submitted claims for services that were medically unnecessary, inappropriate, or of inferior quality and that the provider's continued participation constitutes a threat to the public's or Medicaid recipient's health, welfare, or safety.
- The provider has violated the MFCA, the Health Care False Claim Act,²² or a similar statute of another state or the federal government.
- An overpayment may not be recovered.
- The provider is refusing to:
 - provide the records necessary to document its claims to DCH, the attorney general, or federal authorities; or
 - make or file statutorily required disclosures regarding the ownership of its business or sharing of payments for services provided to Medicaid recipients.

If the director determines that emergency action is warranted, he can summarily suspend all payments to the provider or suspend the provider's participation in Medicaid.²³ The sanctions are effective on the latter of the date specified in the order or the date the order is served on the provider. The order is not stayed by an administrative or judicial appeal.

A hearing is not required before issuing an emergency order. A hearing may be requested

after the order is issued. The hearing is a contested case under the Administrative Procedures Act²⁴ and will determine whether the emergency order is supported by competent, material, and substantial evidence.

If a provider fails to conform to professionally accepted standards of medical practice, the director of DCH may:²⁵

- refuse to enroll the provider
- terminate the providers contract and program participation
- suspend the provider indefinitely or for a specified period of time
- place the provider on probation with controls and supervision on the providers practice and submission of claims

The director must refuse to enroll a provider or terminate a provider's participation in Medicaid if the provider:²⁶

- is convicted of Medicaid fraud, health care fraud, or a substantially similar statute of another state of the federal government
- is convicted of a criminal offense related to the provider's practice of health care in any jurisdiction
- continues or reinitiates a practice for which the provider was previously sanctioned
- dispenses, renders, or provides goods or services without the appropriate physician's order
- attempts to avoid providing or refuses to provide DCH, the attorney general, or the federal government with access to

all records necessary to fully document the goods or services provided to a Medicaid recipient, to fully substantiate each claim and to demonstrate the medical necessity, appropriateness, and quality of service for each claim

- is terminated or suspended from Medicaid, Medicare, or any governmentally funded program in any jurisdiction

In addition, the director must refuse to enroll a provider, suspend or place a provider on probation, or terminate a provider for a broad range of program violations.²⁷ The sanctions are required for, among other things:

- Submission of claims for reimbursement of a fee or charge that is higher than the provider's usual and customary fee
- Inclusion of charges or fees not related to the goods or services provided to the recipient
- Misrepresentation of the identity of the person who actually provided the service, the identity of the recipient, or the date of service
- Misrepresentation of the goods or services provided to the recipient or the recipient's diagnosis, treatment, or the cause of the recipient's medical condition

When a provider is sanctioned by DCH it often triggers sanctions by the federal government, licensing boards, other health care entities, and insurers. These sanctions may lead to additional legal and financial problems, including being required to withdraw from ownership or control of a business that receives Medicaid or Medicare funds.²⁸

If DCH's sanction precludes a person from enrolling in Medicaid or terminates the person's participation, then the person cannot directly or indirectly participate in Medicaid while under the sanction.²⁹ This effectively precludes employment by hospitals, managed care organizations, clinics, and other health care providers that receive funds from Medicaid, Medicare, or other government health care programs.

When precluding or terminating a provider's participation in Medicaid, DCH typically imposes the same sanction as the federal government. Thus, if a provider is excluded from Medicaid for five years by the federal government, DCH will exclude the provider for five years. It should be noted, however, that the termination or denial of enrollment under MCL 400.111e(2) for fraud does not contain any time limits. The exclusion is permanent unless the director determines that the provider's reinstatement is in the best interest of:³⁰

- the Medicaid program; *and*
- the medical care of Medicaid recipients.

Absent such a determination by the director, there is no legal basis to allow a person who has been excluded to participate in Michigan's Medicaid program. Therefore, the mere expiration of a federal exclusion is not enough to allow reinstatement as a provider in Michigan's Medicaid program.

Once a civil or administrative judgment is entered against a provider for an overpayment, the state may collect the judgment from the provider or the provider's corpora-

tion, partnership, business associates, employees, provider group, or successors and assignees.³¹ In addition, the state has a priority lien on all of a provider's assets to recover an overpayment obtained by fraud.³² ♦

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Footnotes

1. *People v Orzame*, 224 Mich App 551, 559-561 (1997).
2. MCL 400.111b(16).
3. *Prechel v Dept of Social Services*, 186 Mich App 547, 549 (1990). See also, MCL 400.111b(10).
4. "Abuse" means health care practices that are substandard, negligent, or unnecessarily increase the cost of health care. Abusive practices may or may not rise to the level of fraud.
5. *Rutherford v Dept of Social Services*, 193 Mich App 326 (1992).
6. MCL 400.602.
7. MCL 750.492a.
8. MCL 750.483a and MCL 750.122.
9. MCL 750.411j et seq.
10. MCL 750.159g et seq.
11. MCL 752.794.
12. MCL 400.607(2).
13. See also, MCL 333.16221 as amended by 2002 PA 402 (effective June 3, 2002) and MCL 333.16226, which defines the sanctions.
14. MCL 400.605(1) and (2).
15. MCL 769.1a(2) and MCL 780.766(2).
16. *People v Gaban*, 456 Mich 264 (1997).
17. MCL 769.1a(13) and MCL 780.766(13).
18. MCL 769.1a(14) and MCL 780.766(14).
19. MCL 400.612.
20. The difference between what was paid on the claim and what would have been paid had the claim been properly submitted.
21. MCL 400.111f(a)-(h).
22. MCL 752.1001 et seq.
23. MCL 400.111f(5).
24. See, MCL 24.271-MCL 24.287 and MCL 24.301-MCL 24.306.
25. MCL 400.111e (d) and 400.111d(1) (a)-(f). See also, 42 USC 1320a-7(b).
26. MCL 400.111e(2) and 400.111d(1)(a) and (c). See also, 42 USC 1320a-7(a).
27. MCL 400.111e(3).
28. MCL 400.111d(2) and 42 USC 1320a-7(b)(8).
29. MCL 400.111e (6).
30. MCL 400.111e(7).
31. MCL 400.111b(24).
32. MCL 400.111a(7)(d).

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