Washington State
House of Representatives
Office of Program Research

BILL ANALYSIS

Ways & Means Committee

ESSB 5960

Brief Description: Concerning medicaid fraud.

Sponsors: Senate Committee on Ways & Means (originally sponsored by Senators Keiser, Pflug and Kline).

Brief Summary of Engrossed Substitute Bill

- Establishes a right for private citizens to file a case on behalf of the government in cases involving Medicaid fraud and to receive a portion of the proceeds from any successful action or settlement.
- Establishes Medicaid theft as a class B felony with a fine up to $50,000.

Hearing Date: 5/20/11

Staff: Chris Blake (786-7392) and Erik Cornellier (786-7116).

Background:

Medicaid.
Medicaid is a health care program for qualifying low-income and needy people, including children, the elderly, and persons with a disability. The program is a federal-state partnership established under the federal Social Security Act, and implemented at the state level with federal matching funds. Each state program must establish a plan that meets specified requirements mandated by the federal Centers for Medicare and Medicaid Services. In Washington, the Department of Social and Health Services is responsible for administering the Medicaid program.

State Medicaid Fraud.
Several activities are restricted to prohibit fraudulent acts by Medicaid service providers. Providers that obtain payments through willful false statements, willful misrepresentations or concealment of material facts, or other fraudulent schemes must repay any excess payments that they received, including interest, and may be assessed civil penalties up to three times the

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amount of the excess payments. In addition, it is a class C felony for any person to knowingly make a false statement or conceal material facts in an application for payment, knowingly make a false statement regarding facts used to determine rights to payments, or have knowledge of the concealment of information with the intent to fraudulently receive unauthorized payments. Other prohibitions relate to inappropriate rebating and referral practices and knowingly charging excessive rates for services to patients.

Federal False Claims Act.
Federal law establishes liability for certain activities involving claims for payment to the United States government. These activities generally relate to:

- presenting a fraudulent claim;
- using false records pertaining to a fraudulent claim;
- failing to return money or property to the government;
- intending to defraud the government through a certification of receipt of property;
- purchasing public property from a government employee who is known not to be authorized to lawfully sell the property; or
- using false records or concealing or improperly avoiding an obligation to pay money to the government.

Violations of the False Claims Act may result in civil penalties between $5,000 and $10,000. In addition, a person who is found to have committed a violation is liable for three times the amount of the damages sustained by the government.

The False Claims Act also allows private citizens to file a case in federal court and sue on behalf of the government. When a private citizen files such an action, the federal government may choose to intervene in the case. If the case prevails, the private citizen is permitted to receive a portion of the proceeds depending upon whether or not the government intervenes in the case. If the government intervenes, then the private individual is generally permitted to receive 15 to 25 percent of the proceeds of the action or settlement. If the government does not intervene in the case, then the private individual is permitted to receive a portion of the claim or settlement determined by the court to be reasonable, but the amount shall not be less than 25 percent or more than 30 percent of the proceeds.

The Deficit Reduction Act of 2005 provides incentives to states to adopt their own versions of the False Claims Act that meet specific criteria and pertain to Medicaid programs. States that enact such laws receive an enhanced portion of the recovery in those cases. The enhanced recovery increases the state's share of the proceeds by 10 percent and reduces the federal recovery by 10 percent. The Inspector General for the U.S. Department of Health and Human Services and the U.S. Attorney General must determine that the state law meets specified criteria, including state liability for false or fraudulent claims that is equivalent to the federal liability, provisions that are at least as effective as federal standards for rewarding actions by private citizens, and civil penalties that are as much or more than the federal penalties.

Summary of Bill:

General Provisions Regarding Medicaid Fraud.
The crime of Medicaid theft is established as a class B felony with a fine up to $50,000. Medicaid theft occurs when a person or corporation either: (1) wrongfully obtains, with intent to

deprive, property or services valued over $5,000 from a medical services program; or (2) obtains, through deception, control over property or services valued over $5,000 from a medical services program with the intent to deprive. Medicaid theft and false statements are added to the definition of "crimes relating to financial exploitation" as that term pertains to licensing individuals with unsupervised access to vulnerable adults.

In addition to the Secretary of the Department of Social and Health Services (DSHS) having authority to assess civil penalties for activities involving false statements or misrepresentations, the Director of the Health Care Authority or the Washington Attorney General (Attorney General) may also assess civil penalties. The Attorney General may also contract with private attorneys and local governments to bring such actions.

The statute of limitations for Medicaid-related felonies is extended from five years to 10 years.

The DSHS may not pay a durable medical equipment provider, prosthetic or orthotic provider, or medical supplies provider unless that provider is a Medicare provider.

Whistleblower protections are provided to employees who report to the DSHS that their employer has fraudulently obtained or attempted to obtain Medicaid benefits or payments. These employees may not be subject to workplace reprisal or retaliatory action; this does not prohibit an employer from terminating, suspending, or disciplining an employee whistleblower for lawful reasons.

The Medicaid Fraud Penalty Account (Account) is established. Civil penalties received from actions against service providers must be deposited into the Account, rather than the State General Fund. In addition, receipts from settlements under either the state or federal False Claims Act must be deposited into the Account.

State Medicaid Fraud False Claims Act.
A state version of the False Claims Act is established pertaining to Medicaid programs. Under these provisions, liability is established for certain activities that involve claims for payment to a state agency that administers Medicaid programs. These activities generally relate to:

- presenting a fraudulent claim;
- using false records pertaining to a fraudulent claim;
- failing to return money or property to the government;
- intending to defraud the government through a certification of receipt of property;
- purchasing public property from a government employee who is known not to be authorized to lawfully sell the property; or
- using false records or concealing or improperly avoiding an obligation to pay money to the government.

Liability for presenting such a claim includes a civil penalty between $5,000 and $10,000 and three times the amount of damages incurred by the state agency. Damages may be reduced if the person making the claim cooperates with the Attorney General's investigation.

A private citizen, known as a "qui tam relator," may bring a civil action for violations of the False Claims Act. Prior to commencing the action, the qui tam relator must serve a copy of the complaint upon the Attorney General and provide him or her with all material evidence regarding

the claim. The Attorney General has at least 60 days following the receipt of the complaint and the evidence to decide whether or not to intervene in the action.

If the Attorney General intervenes in the action, he or she has the primary responsibility for prosecuting the action. If such an action is successful, the qui tam relator must receive between 15 and 25 percent of the proceeds from the action or any settlement, depending upon the extent of the qui tam relator's contribution to the action. The award to the qui tam relator is limited to no more than 10 percent of the proceeds if the action is based on information, other than that provided by the qui tam relator, such as information obtained through an adjudicative proceeding or government report or audit. In addition, the Attorney General and the qui tam relator must be awarded reasonable expenses and attorneys' fees.

If the Attorney General decides not to intervene in the action, then the qui tam relator may choose to continue to pursue the case. If such an action is successful, the court shall award the qui tam relator an amount that it determines to be reasonable, but it must award between 25 and 30 percent of the proceeds from the action or any settlement. In addition, the qui tam relator must be awarded reasonable expenses and attorneys' fees.

If the Attorney General decides not to intervene in the action and the defendant prevails, the court may award the defendant reasonable costs and attorneys' fees to be paid by the qui tam relator.

Funds recovered and remaining after distributions to the qui tam relator must be returned to the agency administering the Medicaid program being defrauded and the remainder to the Medicaid Fraud Penalty Account. Qui tam actions may not be brought that are based on the subject of a civil suit or a civil proceeding in which the Attorney General is already a party. Remedies are provided to employees who suffer workplace discrimination or reprisals because of participation in a false claims action. Jurisdiction, discovery rules, and other procedures are specified for false claims actions.

Beginning November 15, 2012, the Attorney General must report annually on the results of implementing the Medicaid False Claims Act, including the number of attorneys assigned to qui tam actions, the number of actions brought, the results of the actions brought, and the amount of the recoveries attributable to the Medicaid False Claims Act.

Appropriation: None.

Fiscal Note: Available. New fiscal note requested on May 17, 2011.

Effective Date: The bill contains an emergency clause and takes effect immediately.