HOUSE BILL REPORT
ESSB 5960

As Reported by House Committee On:
Ways & Means

Title: An act relating to medicaid fraud.

Brief Description: Concerning medicaid fraud.

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

Brief History:
Committee Activity:
Ways & Means: 5/20/11, 5/23/11 [DPA].

Brief Summary of Engrossed Substitute Bill
(As Amended by House)

- Establishes the Medicaid Fraud False Claims Act (Act) to allow the Attorney General to bring civil actions for certain violations of fraud and false claims provisions and establishes civil penalties between $5,000 and $10,000 and awards of treble damages for violations.
- Establishes a right for private citizens to receive 15 to 25 percent of the proceeds from any successful action or settlement achieved by the Attorney General under the Act based upon information provided by the private citizen.
- Establishes Medicaid theft as a class B felony with a fine up to $50,000.

HOUSE COMMITTEE ON WAYS & MEANS

Majority Report: Do pass as amended. Signed by 26 members: Representatives Hunter, Chair; Darneille, Vice Chair; Hasegawa, Vice Chair; Alexander, Ranking Minority Member; Bailey, Assistant Ranking Minority Member; Dammeier, Assistant Ranking Minority Member; Orcutt, Assistant Ranking Minority Member; Carlyle, Chandler, Cody, Dickerson, Haigh, Haler, Hinkle, Hudgins, Hunt, Kagi, Kenney, Ormsby, Parker, Ross, Schmick, Seaquist, Springer, Sullivan and Wilcox.

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

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not a part of the legislation nor does it constitute a statement of legislative intent.

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 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;
- using false records or concealing or improperly avoiding an obligation to pay money to the government; or
- conspiring to commit any of the specified violations.

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 cannot 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 Amended 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 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. The Account may only be used for Medicaid services and Medicaid fraud enforcement activities.

State Medicaid Fraud False Claims Act.

The "Medicaid Fraud False Claims Act" (Act) is established as a state version of the False Claims Act pertaining to Medicaid programs, except without qui tam provisions. The Act establishes liability 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;
- using false records or concealing or improperly avoiding an obligation to pay money to the government; or
- conspiring to commit any of the specified violations.

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.

Any person who is the original source of information used by the Attorney General to bring a claim of a violation of the Act may receive between 15 and 25 percent of any recovery that the Attorney General is awarded for the claim. The courts are required to determine the exact percent of the person's recovery. Remedies are provided to employees who suffer workplace discrimination or reprisals because of participation in a false claims action.

Beginning November 15, 2012, the Attorney General must report annually on the results of implementing the 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 Act.

Amended Bill Compared to Engrossed Substitute Bill:

The Ways & Means Committee amendment removes all of the qui tam provisions and authorizes any person who is the original source of information used by the Attorney General in a Medicaid fraud case to receive between 15 and 25 percent of the attorneys' fees, unless the person was involved in the conduct that is the subject of the suit.

Appropriation: None.

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

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

Staff Summary of Public Testimony:

(In support) This bill represents an opportunity for the state to recover millions of dollars of stolen taxpayer money by extending the statute of limitations on Medicaid fraud crimes to 10 years. The Attorney General's Medicaid Fraud Control Unit has a current backlog of over 100 cases. The cases will die unless the statute of limitations is extended. Qui tam provisions are the key to discovering Medicaid fraud because the private individuals who report these situations are in a unique position to discover the fraud. The Medicaid Fraud Penalty Account will provide a funding mechanism to carry out litigation at almost no cost to the state. The state could get additional fraud recoveries from being able to participate in national cases filed in other states if Washington's qui tam statute is complaint with federal standards. The most effective, efficient, and low cost way to pursue Medicaid fraud cases is through qui tam provisions where the Attorney General is in charge of the litigation.

(With concerns) There is strong support for the purpose of the bill to encourage whistleblowers to come forward, although there is opposition to its current form because it requires the whistleblower to pay attorneys' fees if they lose the claim. Twenty-eight states and the federal government have been allowing for qui tam actions for many years with success. Requiring whistleblowers to pay attorneys' fees if they lose will prevent people from coming forward with reports of fraudulent activity. The state needs to go after fraud which takes money from other valuable programs. More money could be recovered if the attorneys' fee provision were modified.

(Opposed) While the goal of reducing Medicaid fraud is worthwhile, the qui tam provisions will open business to frivolous litigation and put small businesses in jeopardy. Small businesses are most likely to be the targets of settlements in state level qui tam suits because they are least able to defend themselves. This bill will increase litigation for health care facilities and providers.

The bill's qui tam approach will have unintended consequences for physicians and their participation in the Medicaid program. The bill will increase the number of meritless claims because of its financial incentives. The existing statutes should be fully funded and enforced. There should be a financial reward for those who report Medicaid fraud, without the extensive private rights that are in a qui tam action.

The Attorney General has successfully litigated Medicaid fraud claims without qui tam provisions. Because qui tam actions require that additional funds be distributed to the qui tam relator, the state's recoveries for Medicaid fraud could be reduced.

The approach that Missouri has taken, which grants a 10 percent finder's fee to those who report fraud, works best for identifying fraud. The 75 percent federal match for the Attorney General's Medicaid fraud activities is available regardless of having a qui tam provision. The award of attorneys' fees to defendants is permissive and should be mandatory because courts rarely award attorneys' fees to defendants.

Persons Testifying: (In support) Aileen Miller, Office of the Attorney General.

(With concerns) Jesse Wing, Washington Employment Lawyers Association; and Lonnie Johns-Brown, Welfare Advocates Group.

(Opposed) Patrick Connor, National Federation of Independent Businesses; Tim Layton, Washington State Medical Associaiton; Lisa Thatcher, Washington State Hospital Association; Cliff Webster, Pharmaceutical Research and Manufacturers of America; and Mel Sorenson, Washington Defense Trial Lawyers Association.

Persons Signed In To Testify But Not Testifying: None.