SENATE BILL REPORT
SB 5960

As of May 18, 2011

Title: An act relating to medicaid fraud.

Brief Description: Concerning medicaid fraud.

Sponsors: Senator Keiser.

Brief History:
Committee Activity: Ways & Means: 5/18/11.

SENATE COMMITTEE ON WAYS & MEANS

Staff: Tim Yowell (786-7435)

Background: Through the Medicaid program, the state and federal governments will spend an estimated $8.8 billion per year during the 2011-13 biennium to provide medical, dental, behavioral health, and long-term care to an average of 1.2 million low-income Washingtonians each month. Medicaid funding and services are administered by the Department of Social and Health Services (DSHS) through its Medical Assistance and Aging and Adult Services administrations.

Medicaid fraud is generally defined as the billing of the Medicaid program for services, drugs, or supplies that are unnecessary, not performed, or of a lower quality; more costly than those actually performed; and purportedly covered items which were not actually covered. Medicaid provider billings are routinely reviewed and analyzed by the DSHS Office of Program Integrity for compliance with program standards and billing instructions. Billings where potential fraud is suspected are referred to the Medicaid Fraud Control Unit (MFCU) in the Office of the Attorney General (AG) for investigation and possible prosecution. The statute of limitations for the crime of Medicaid fraud is either three or five years, depending upon the particular statute under which charges are brought. In addition to recovering the amount wrongfully obtained plus interest, the Secretary of DSHS may assess civil penalties up to three times the amount wrongfully obtained.

In addition to investigating and seeking recovery of fraud cases originating in Washington, the MFCU also administers funds that are recovered for the Washington Medicaid program from multi-state cases that are pursued nationally under the federal False Claims Act. MFCU recoveries under state and federal actions presently average about $19 million per year. Of

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that total, approximately $14.5 million per year is returned to the DSHS to offset the state and federal cost of Medicaid services. The remaining $4.5 million are from penalty and interest payments that are deposited into the General Fund.

Under the federal False Claims Act, a private citizen, known as a *qui tam* relator, may initiate a civil action on behalf of the government to recover damages in cases of alleged Medicaid fraud. At least 24 states have enacted similar *qui tam* provisions in state law. Washington has not.

Summary of Bill: The crime of Medicaid theft is moved from the theft statutes to the section relating to Medicaid false statements. The statute of limitations for prosecuting Medicaid theft and Medicaid false statement cases is ten years.

In addition to the Secretary of DSHS, the AG may also assess civil penalties of up to three times the amount wrongfully obtained.

The Medicaid Fraud Penalty Account is established. All receipts from filings under the federal and this state false claims act are deposited into the account. The account is subject to appropriation, and may only be used for Medicaid fraud enforcement activities and the cost of Medicaid services.

In order to be paid for Medicaid services, providers of durable medical equipment, orthotics, prosthetics, and supplies must also be providers under the federal Medicare program.

A person who presents a false Medicaid claim for payment or approval is subject to a civil penalty of between $5,000 and $10,000 and treble damages received by the state. This penalty may be reduced to double damages if the person cooperates with the AG's investigation. The AG must make a good faith investigation of false Medicaid claims and may bring civil actions, subject to funds appropriated for this purpose. The AG may contract with private attorneys and local governments in bringing fraud actions. Jurisdiction, discovery rules, and other procedures are specified for false claims actions.

Whistleblower protections are provided to employees who report to 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. Employees who suffer workplace discrimination or reprisals because of participation in a false claims action are provided remedies that include reinstatement, two times the back pay that would have been earned plus interest, and compensation for any special damages sustained.

Qui tam actions are permitted. A person, known as a relator, may bring a civil action on both their own behalf and that of the state alleging submission of a false Medicaid. The AG may intervene in the *qui tam* action and the relator may continue as a party, and receive between 15 and 25 percent of the recoveries. If the action is based on disclosures other than those provided by the relator, the relator may receive no more than 10 percent of the recoveries. The relator may conduct the action if the AG does not, and the relator may receive between 25 and 30 percent of the recoveries should this occur. *Qui tam* actions may not be brought

that are based on the subject of a civil suit or a civil proceeding in which the AG is already a party.

If the plaintiff prevails in the *qui tam* action, the relator and the AG must be reimbursed for reasonable expenses and attorneys' fees by the defendant. If the defendant prevails, the court may award reasonable expenses and attorneys' fees to the defendant, to be paid by the relator.

The AG is to report annually on the number of cases brought under *qui tam* actions and their results, delineated between those brought by the AG and those brought by relators without AG participation.

Appropriation: None.

Fiscal Note: Requested May 18, 2011.

Committee/Commission/Task Force Created: No.

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

Staff Summary of Public Testimony on HEA Recommended Substitute Bill 5458: PRO: Nationwide, Medicaid fraud is estimated to comprise 3 to 5 percent of Medicaid expenditures. Washington spend $8.5 billion per year on its Medicaid Program, yet recovers only about $20 million per year from fraudulent billings. It is essential that we do a better job recovering funds that have been fraudulently billed to the state's taxpayers. Twenty-eight states plus New York City and Chicago have state false claims acts. Qui tam and whistleblower provisions are essential, because for a fraud recovery program to be effective, the people with inside knowledge need to have the protections and incentives to come forward.

CON: Washington already conducts a very effective false claims effort under current statutes. It doesn't need to rely upon qui tam bounty hunters who would be entitled to up to 30 percent of the recoveries that could otherwise go to the state, plus court costs and attorney fees. There is no statute of limitations with regard to qui tam actions, so it would be very expensive for the Attorney General to keep track of all of them. A Columbia Law Review article reported that over 70 percent of all qui tam actions were frivolous.

Persons Testifying: PRO: Senator Keiser, prime sponsor; Jesse Wing, Washington Employment Lawyers Association.

CON: Cliff Webster, Pharmaceutical Research and Manufacturers of America; Mel Sorensen, Washington Defense Trial Lawyers; Lisa Thatcher, Washington State Hospital Association; Tim Layton, Washington State Medical Association.