SENATE BILL REPORT
SB 5978

As of January 24, 2012

Title: An act relating to medicaid fraud.

Brief Description: Concerning medicaid fraud.

Sponsors: Senators Pflug, Keiser, Frockt, Conway and Kohl-Welles.

Brief History:
Committee Activity: Health & Long-Term Care: 12/08/11, 1/09/12 [DPS-WM, w/oRec]. Ways & Means: 1/24/12.

SENATE COMMITTEE ON HEALTH & LONG-TERM CARE

Majority Report: That Substitute Senate Bill No. 5978 be substituted therefor, and the substitute bill do pass and be referred to Committee on Ways & Means.
Signed by Senators Keiser, Chair; Conway, Vice Chair; Frockt, Kline and Pflug.

Minority Report: That it be referred without recommendation.
Signed by Senators Becker, Ranking Minority Member; Carrell and Parlette.

Staff: Kathleen Buchli (786-7488)

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. The Medicaid Fraud Control Unit in the Office of the Attorney General (AG) investigates cases of suspected fraud.

Under the Federal False Claims Act, entities that submit false or fraudulent claims for federal government funds may be liable for a civil penalty of between $5,500 and $11,000. A person, known as a qui tam relator, may bring an action on behalf of the United States Government. Qui tam relators share in the proceeds of recoveries awarded to the United States Government. Shares vary between 10 and 30 percent of the recoveries, depending on

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the level of relator participation and are determined by the court. The Deficit Reduction Act amended the Social Security Act and provided that states are eligible for a ten percentage point rebate with respect to medical assistance recoveries made under state action if: the state establishes liability for false or fraudulent claims relating to its medical assistance program, the state enacts a state false claims act that is at least as effective in rewarding and facilitating qui tam actions for false or fraudulent claims as the federal law provides, actions are filed under seal for 60 days with review by the AG, and the state establishes a civil penalty that is not less than the amount provided in the Federal False Claims Act. Twenty-seven states have enacted State False Claims Acts and have undergone review by the Office of the Inspector General.

Summary of Bill (Recommended Substitute): Medicaid Program Provisions. 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.
The director of the Health Care Authority (HCA) and the AG may assess civil penalties of up to three times the amount wrongfully obtained.

The Medicaid Fraud Penalty Account is established. All receipts from civil penalties collected by the HCA and the AG and all receipts received under settlements that originated under the Federal or State False Claims Acts must be deposited into the account. The account is subject to appropriation, and may only be used for Medicaid services, fraud detection and prevention activities, recovery of improper payments, and for other Medicaid fraud enforcement activities.

In order to be paid for Medicaid services, providers of durable medical equipment 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 $5,500 and $11,000 and treble damages received by the state. This penalty may be reduced to double damages if the person cooperates with the AG's investigation. If the person is found to have fraudulently billed for services, their insurer is not obligated to pay claims on the person's behalf. The AG is to diligently investigate false Medicaid claims and may bring civil actions. The AG may contract with private attorneys and local governments in bringing fraud actions. Whistleblowers who report to the HCA that their employer has fraudulently obtained or attempted to obtain Medicaid benefits or payments may not be subject to workplace reprisal or retaliatory action.

State False Claims Act. A State False Claims Act is created, permitting qui tam actions. 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 billing. The relator must serve a copy of the complaint on the AG and the complaint must be filed in camera. The AG may intervene in the qui tam action and the relator may continue as a party to the action. If the AG does not intervene, the relator may proceed with action unless dismissed by the court. A qui tam action may not be brought if it is based on a proceeding in which the AG is already a party. The court may dismiss an action if the action is publicly disclosed in a federal criminal, civil, or administrative hearing in which the AG is a party or in a government report or by the news media. If the relator has been retaliated against, the relator is entitled to relief necessary to

make the employee whole; this includes reinstatement, two times the amount of back pay with interest, and special damages. 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.

If the AG Intervenes in the Qui Tam Action. The AG may move to dismiss the action if the relator has been given notice and opportunity for a hearing or settle the action if the court determines that the settlement is fair and reasonable. The court may put limitations on the relator's participation if the court determines that such participation would interfere with the action or is repetitious, irrelevant, or to harass. The court may limit the number of witnesses called by the relator and the amount of their participation. If the defendant shows that unrestricted participation of the relator would be for purposes of harassment or cause undue burden or expense, the court may limit participation by the relator. The relator will receive between 15 percent and 25 percent of the proceeds of the action or settlement, depending on the extent of the relator's participation and as determined by the court. If the court determines that the action is based on information other than that provided by the relator, the relator may be awarded no more than 10 percent of the proceeds. Payments to the relator must be from the proceeds and the relator is due reasonable expenses, plus reasonable attorneys' fees and costs. All expenses, fees, and costs will be awarded against the defendant.

If the AG Does Not Intervene in the Qui Tam Action. As requested by the AG, the relator must serve copies of all pleadings and depositions on the AG. The court may permit the AG to intervene at a later date upon a showing of good cause. The relator will receive between 25 percent and 30 percent of the proceeds of the action or settlement, as determined by the court. The relator must also receive an amount for reasonable expenses, attorneys' fees, and costs. All expenses, fees, and costs will be awarded against the defendant. If the defendant prevails, the court may award to the defendant reasonable attorneys' fees and expenses if the court finds the claim was clearly frivolous, clearly vexatious, or brought primarily for the purposes of harassment.

EFFECT OF CHANGES MADE BY HEALTH & LONG-TERM CARE COMMITTEE (Recommended Substitute): Provides that civil penalties received by the AG are to be deposited into the Medicaid Fraud Penalty Account. Money in the account may only be spent for Medicaid services, fraud detection and prevention activities, recovery of improper payments, and for other Medicaid fraud enforcement activities. The qui tam action may be dismissed during the period that it is under seal only if the court and the AG gives written consent to the dismissal and the reason for consenting. If the action continues with a qui tam relator, the AG may request copies of all pleadings. These copies will be submitted at the AG's expense and not the relator's expense. The relator is not required to provide the AG with notice or details of offers of settlement. Removes the requirement that providers of orthotics and prosthetics by Medicare providers be paid under the Medicaid program. Removes the requirement that the AG investigations be subject to funds appropriated; instead, the AG is directed to investigate violations.

Appropriation: None.

Fiscal Note: Available.

Committee/Commission/Task Force Created: No.

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

Staff Summary of Public Testimony (Health & Long-Term Care):
Testimony From 2011 Second Special Session.
PRO: This is a bipartisan weapon. States cannot share information about cases under seal, while they are under seal. Washington will find out about these cases only when the other party moves the court to lift the seal; this only happens at the end of the cases and Washington will not have influence on the terms of the settlement. Cases of Medicaid fraud do happen here and Washington has no way to get access to these cases without having a False Claims Act. The Federal False Claims Act and State False Claims Acts are successful programs to recover funds. Having a False Claims Act will permit the AG to be at a settlement table and determine how much the defendants should pay; this does not happen in Washington today. Permitting whistleblowers to recover under the False Claims Act is necessary because you need to incentivize rational people to take on the risk of blowing the whistle on their employers. A small percentage of cases proceed when the government declines to intervene. It would generate meaningful revenue for the state. Washington spent $6.6 billion on Medicaid in 2009. The General Accounting Office has found that approximately 10 percent of government health care dollars are lost to fraud each year, this translates to $660 million for Washington per year.

CON: Washington has very good tools now for dealing with Medicaid fraud. Most information comes from audits made by the Medicaid Fraud Control Unit. Even without a qui tam statute, Washington is a state that defendants want to settle with because current awards of treble damages. We believe that litigants should be treated similarly and should be a true loser pays situation. We support efforts to combat Medicaid fraud and we support whistleblower protections and incentives; this can be best accomplished by providing a reward or incentive for the claimant rather than a qui tam provision. It is not practical to come into compliance with federal law because as the federal law changes the Legislature will have to continually amend its law to respond. Permitting a private relator creates an unnecessary and litigious environment. Whistleblower incentives can be provided through a finders fee. We can participate in other state settlements and there is nothing left that Washington does not get from these cases. The state does have access to documents that are under seal. If the intention is to give an incentive to whistleblowers, Missouri's approach can be used. Missouri does not have a qui tam system but rates fifth in total recoveries nationwide.

OTHER: This Act will target individual providers, not just pharmaceutical companies and large providers. Extending the statute of limitations for Medicaid fraud actions will make it difficult to defend and burdens defendants who need to gain access to witnesses to defend themselves. The knowingly standard does not require specific intent, this is burden to the providers to demonstrate that their billings are accurate. While only 20 percent of qui tam complaints are taken up by the federal government, the remaining 80 percent of cases must be investigated the same way which increases the expenses to the government. This would turn away small providers from taking Medicaid patients. Prosthetics and orthotics providers should be removed from the requirement that they be Medicare providers. The General

Accounting Office has found that approximately 10 percent of government health care dollars are lost to fraud each year, this translates to $660 million for Washington per year.

Persons Testifying (Health & Long-Term Care):
Persons Testifying From 2011 Second Special Session.
PRO: Senator Pflug, Prime Sponsor; Jeff Sprung, WA State Association for Justice; Jessie Wing, WA Employment Lawyers Association; Cynthia Fitzgerald, Whistleblower.

CON: Cliff Webster, Liability Reform Coalition; Denny Maher, WA State Medical Association; Mel Sorenson, WA Defense Trial Lawyers; Lisa Thatcher, WA State Hospital Association; Patrick Connor, National Federation of Independent Business.

OTHER: Amanda Lee, WA Association of Criminal Defense Lawyers, WA Defender Association; Dave Hensley, WA Orthotics and Prosthetics Association; Dawn Cortez, Medicaid Fraud Control Unit/AG.