SENATE BILL REPORT
ESHB 1067

As Reported by Senate Committee On:
Accountability & Reform, February 24, 2016

Title: An act relating to the medicaid fraud false claims act.

Brief Description: Reauthorizing the medicaid fraud false claims act.

Sponsors: House Committee on Judiciary (originally sponsored by Representatives Jinkins, Holy, Magendanz, Nealey, Goodman, Muri, Gregerson, Cody, Kilduff and Pollet; by request of Attorney General).

Brief History: Passed House: 6/24/15, 58-39; 6/28/15, 56-41; 2/12/16, 88-8.
Committee Activity: Accountability & Reform: 2/24/16, 2/24/16 [DP-WM].

SENATE COMMITTEE ON ACCOUNTABILITY & REFORM

Majority Report: Do pass and be referred to Committee on Ways & Means.
Signed by Senators Miloscia, Chair; Padden, Vice Chair; Fraser, Ranking Member; Dansel and McAuliffe.

Staff: Karen Barrett (786-7413)

Background: Through the Medicaid program, the state and federal government will spend an estimated $8.3 billion per year during the 2015-17 biennium to provide medical, dental, behavioral health, and long-term care to an average of 1.8 million low income Washingtonians per month.

The Washington State Health Care Authority (HCA) administers the Medicaid program, and the consumer protection division of the Attorney General's Office receives and may investigate suspected provider fraud. Providers who submit false or fraudulent claims for Medicaid reimbursement face a civil penalty of between $5,500 and $11,000 and up to three times damages sustained by parties to the lawsuit.

Citizens may bring action on behalf of this publically funded medical assistance program. Such persons are referred to as qui tam relators. Qui tam relators share in proceeds of fraud recoveries awarded by the court when cases are successfully litigated. As an incentive for states to adopt similar laws, a 10 point rebate can be earned so long as the state's own Fair

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Claims Act proves as effective in rewarding and facilitating qui tam actions as that experienced by the U.S. Inspector General.

The 2012 Legislature directed the Legislative Auditor to conduct a sunset review of the Medicaid Fraud False Claims Act. The Joint Legislative Audit and Review Committee finished its evaluation in December, 2015 and recommends continuance citing a positive return per dollar spent to investigate and a 28 percent rise in recoveries since enabled. The Medicaid Fraud False Claims Act will expire on June 30, 2016, unless affirmed and reenacted.

Summary of Bill: All but the qui tam provisions of the Medicaid Fraud False Claims Act are permanently codified. Qui tam provisions remain enforceable for seven more years and expire in 2023 unless affirmed and reenacted by the Legislature. Repeal directives in the code are adjusted accordingly.

Appropriation: None.

Fiscal Note: Available.

Committee/Commission/Task Force Created: No.

Effective Date: Ninety days after adjournment of session in which bill is passed.

Staff Summary of Public Testimony: PRO: This bill protects consumers and taxpaying citizens for whom we invest considerable sums on health care for low income persons. Reauthorization preserves an important tool and unit within the Office of the Attorney General. For every dollar spent on investigation through the Medicaid Fraud Control Unit, $3 goes back into the fraud penalty account. No qui tam cases brought to date have been ruled frivolous by the courts. The Medicaid Fraud Control Unit helps prevent loss and convey lessons that supports program efforts to deter false claims.

Persons Testifying: PRO: Representative Jinkins, Prime Sponsor; Mike Webb, Doug Walsh, Attorney General's Office.

Persons Signed In To Testify But Not Testifying: Cliff Webster, Coalition for Liability Reform.