FINAL BILL REPORT
SB 6053

C 63 L 18
Synopsis as Enacted

Brief Description: Concerning medicaid fraud false claims civil penalties.

Sponsors: Senators Keiser, Frockt, Pedersen, Kuderer and Mullet; by request of Attorney General.

Senate Committee on Law & Justice
House Committee on Judiciary

Background: Medicaid. Medicaid pays medical and related benefits for eligible low-income persons including children, the elderly, and persons with a disability. Each state designs and administers its own Medicaid program within broad federal guidelines. The federal government matches federal funds with state funds to pay for the program as long as the program complies with the federally-mandated requirements. The federal match percentage varies among states from 50 to 83 percent based on the state's per capita income for a particular year; a lower state per capita income results in a higher federal match percentage. The Washington State Health Care Authority, in collaboration with the Department of Social and Health Services, administers the state's Medicaid funding and services.

Medicaid covered services include hospital care, skilled nursing home care, residential adult family care services, and professional services provided by physicians and laboratories. Washington Medicaid also includes hospice, mental health, dental services, and eyeglasses. Medicaid recipients may receive care from many health care provider types such as drug manufacturers, doctors, nurses, clinics, hospitals, nursing homes, adult family homes, assisted living facilities, medical laboratories, ambulance and transportation companies, and companies providing home health services and medical equipment.

Washington State's Medicaid Fraud Control Unit (MFCU). The MFCU is part of the Office of the Attorney General and is comprised of attorneys, investigators, auditors, and others. The unit is responsible for both criminal and civil investigation and prosecution of health care provider fraud committed against the state's Medicaid program by Medicaid providers and contractors. The unit also monitors complaints of resident abuse or neglect in Medicaid funded nursing homes, adult family homes, and boarding homes assisting local law enforcement in investigating and prosecuting crimes committed against vulnerable adults.

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.

Federal and Washington State Medicaid False Claims Laws. Federal laws impose potential criminal penalties, civil fines, provider debarment, and health care license sanctions for violations of Medicaid federal fraud and abuse laws. Under the civil federal False Claims Act (FCA), providers are liable for submitting claims to Medicare or Medicaid that the provider knows, or should know, are fraudulent or based on false records or statements. Liability requires no specific intent to defraud. The financial consequences for submitting false claims include treble damages—damages proved multiplied by three—plus penalties of between $5,500 and $11,000 for each false claim submitted.

Qui Tam Whistleblower Cases. The federal FCA contains whistleblower, or qui tam, provisions allowing private persons, called relators, to file lawsuits in federal court against individuals and entities that submit false claims. Under federal law, the Department of Justice must investigate the relator's allegations and may intervene and take over prosecution of the case. Relators receive a portion of the recovery in successful qui tam cases.

The Federal Deficit Reduction Act of 2005 (DRA). The 2005 federal DRA created a financial incentive for states to enact laws establishing liability to the state for false claims to the state's Medicaid programs. If a state's FCA meets the federal requirements, the federal match returned to the federal government from the awards in a state FCA case will be decreased by 10 percent. For example, if a state's federal match is 50 percent, the state would typically keep 50 percent of the recovery and 50 percent of the recovery would go the federal government. With a DRA 2005-qualified state FCA law, the state would receive 60 percent and the return to the federal government would be 40 percent.

In 2012, Washington enacted its Medicaid Fraud False Claims Act with qui tam provisions. The act expanded the MFCU's criminal authority by granting the MFCU the ability to prosecute fraud using the civil justice system. Under Washington's current Medicaid Fraud FCA law, the civil amount was set at no less than $5,500 and no more than $11,000 per claim. Each year the Office of the Attorney General must adjust these civil penalties to the same level as the federal FCA.

Summary: Washington intends its Medicaid FCA to qualify under the federal DRA of 2005 for the incentive allowing the state to retain an additional 10 percent of the civil penalties recovered under state law. The civil penalties are:

- not less than the greater of $10,957 or the minimum inflation adjusted penalty amount under the federal FCA per claim; and
- not more than the greater of $21,916 or the maximum inflation adjusted penalty imposed under the federal FCA.

The Office of the Attorney General is not required to adjust the civil penalty each year through administrative rulemaking to maintain equivalent civil penalties to the federal FCA.

Votes on Final Passage:

Senate	47	0
House	98	0

Effective: June 7, 2018