22-04 FINAL REPORT:

Sunset Review of Medicaid Fraud Qui Tam Provisions

LEGISLATIVE AUDITOR'S CONCLUSION:

The Legislature should reauthorize the qui tam provisions in the Medicaid Fraud False Claims Act because the process works as intended and maximizes recoveries for the state.

November 2022

Executive Summary

Medicaid is a joint federal-state program that pays providers who deliver health care to eligible populations. Medicaid fraud is a type of fraud in which health care providers knowingly submit false claims for payment. Medicaid fraud increases costs for the state and federal government and may result in patient harm.

This report focuses on one specific method for reporting civil fraud called "qui tam[1]," as authorized by the 2012 Medicaid Fraud False Claims Act (the Act, Chapter 74.66 RCW).

Qui tam provisions in the Medicaid Fraud False Claims Act allow private parties to file complaints in civil court on the state's behalf

The Act authorizes Washington's Office of the Attorney General (AGO) to pursue civil cases against Medicaid providers that are suspected of committing fraud. It includes qui tam provisions that allow private third parties (called relators) to file a complaint alleging Medicaid fraud in state or federal civil court on the state's behalf.

If the AGO finds sufficient evidence that fraud occurred, it seeks a financial recovery[2] for the state through settlement with the provider or a court judgment. The relator receives a portion of the recovery.

After an initial JLARC review of the entire Act in 2015, the 2016 Legislature extended the sunset date for the qui tam provisions to allow more time for oversight and review. The rest of the Act's provisions were extended without a sunset. The qui tam provisions will sunset on June 30, 2023, unless the Legislature reauthorizes them (RCW 43.131.419).

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[1]Qui tam originates from a Latin phrase meaning "he who prosecutes for himself as well as the King."
[2]The recovery amount is the financial compensation that the state receives through settlement or court judgment. It may include the amount of fraudulent reimbursement, damages, penalties, and interest.

The AGO fulfills its statutory responsibilities

The AGO investigates all state qui tam cases[3] and decides whether to pursue legal action. The AGO also investigates multistate qui tam cases[4] and non-qui tam cases.

The AGO considers several factors during its investigation, including the nature of allegations, strength of evidence, potential recovery amount, and patient harm.

Once the AGO completes an investigation, it can take one of three actions:

- Decline to take legal action. The relator can pursue the case on their own or request dismissal.
- Settle with the provider.
- Proceed with litigation against the provider (also called "intervention").

During the study period, the AGO complied with all of the statutory requirements in Chapter 74.66 RCW.

Relators filed 19 state qui tam cases during the study period. One case was ruled "clearly frivolous."

During the study period, federal fiscal years 2016 through 2022[5], relators filed 19 state qui tam cases. Twelve of these have been resolved. The AGO declined to take legal action in eight, settled three, and litigated one. As of August 2022, the remaining seven cases were still under seal[6].

Opponents of the qui tam provisions passed in 2012 expressed concerns about the potential for numerous frivolous lawsuits. Per statute, a provider can request a court to make a frivolous determination after three conditions are met: the AGO declines to pursue legal action, the relator continues the case on their own, and the court rules in favor of the provider. Even if these conditions are met, courts have indicated that they reserve such rulings for "rare and special circumstances." Of the 12 resolved state cases in Washington, one was found by the court to be clearly frivolous.

The AGO recovered eighteen times more than it spent

During the study period, the AGO opened 499 civil Medicaid fraud cases. This includes state and multistate cases that are both qui tam and non-qui tam. The AGO spent $4.0 million in state funds investigating these cases and recovered $71.8 million for the state's Medicaid program, including $62.6 million from qui tam recoveries. The state's return on investment (ROI) was $17.76 for every dollar spent.

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[3]Cases that only involve Washington. Some cases may also name the federal government.
[4]Cases that involve two or more states and the federal government.
[5]Federal fiscal year 2022 includes eleven months of data, from October 1, 2021 through August 31, 2022.
[6]The case is under seal during the AGO's investigation. Only the court, the relator, the AGO, and the federal government (if named) are aware of the case. The provider does not have access to court documents while it is under seal.

The state's qui tam process works as intended to combat Medicaid fraud and maximize recoveries for the state

JLARC staff found that the AGO implements the qui tam provisions consistent with legislative intent. The provisions provide a method for reporting fraud, allow the AGO to participate in multistate cases, and maximize Washington's financial recoveries. If the provisions were to sunset, Washington would lose a method for identifying Medicaid fraud, access to multistate investigations, and the potential for financial compensation through recoveries.

Legislative Auditor Recommendation

The Legislative Auditor recommends reauthorizing the qui tam provisions in the Medicaid Fraud False Claims Act and making them permanent because the process meets legislative intent and maximizes recoveries for the state.

The AGO and OFM concur with this recommendation. You can find additional information in Recommendations.

Committee Action to Distribute Report

On November 30, 2022 this report was approved for distribution by the Joint Legislative Audit and Review Committee. Action to distribute this report does not imply the Committee agrees or disagrees with Legislative Auditor recommendations.

1. Qui tam is a method for reporting fraud

Qui tam provisions allow private parties to file a complaint in civil court on the state's behalf against a Medicaid provider suspected of fraud

Medicaid is a government health insurance program for eligible populations

Medicaid is a joint federal-state program that pays providers for health care delivered to people who meet certain criteria. The state and federal government share the cost of the program.

Washington's Medicaid program is part of Apple Health, a program administered by the Washington State Health Care Authority. It provides health insurance to eligible populations, including children and their parents, pregnant women, people with disabilities, and people age 65 and older. Income eligibility requirements[7] vary across the populations served.

[7]Most eligible populations must have an individual income at or below 133% of the federal poverty level.

As of April 2022, 2.2 million of Washington's 7.8 million residents (29%) were enrolled in Apple Health.

The state's Medicaid Fraud Control Division pursues Medicaid provider fraud

The Office of the Attorney General (AGO) operates Washington's Medicaid Fraud Control Division, which investigates and litigates Medicaid fraud committed by health care providers. Medicaid fraud occurs when a health care provider knowingly submits a false claim for reimbursement. Examples of fraudulent activities include:

- Billing for services not performed.
- Billing multiple times for one service.
- Falsifying a diagnosis.
- Billing for a more costly service than performed.
- Ordering excessive or inappropriate tests.
- Prescribing medicines, performing services, or ordering durable medical equipment that are not medically necessary.

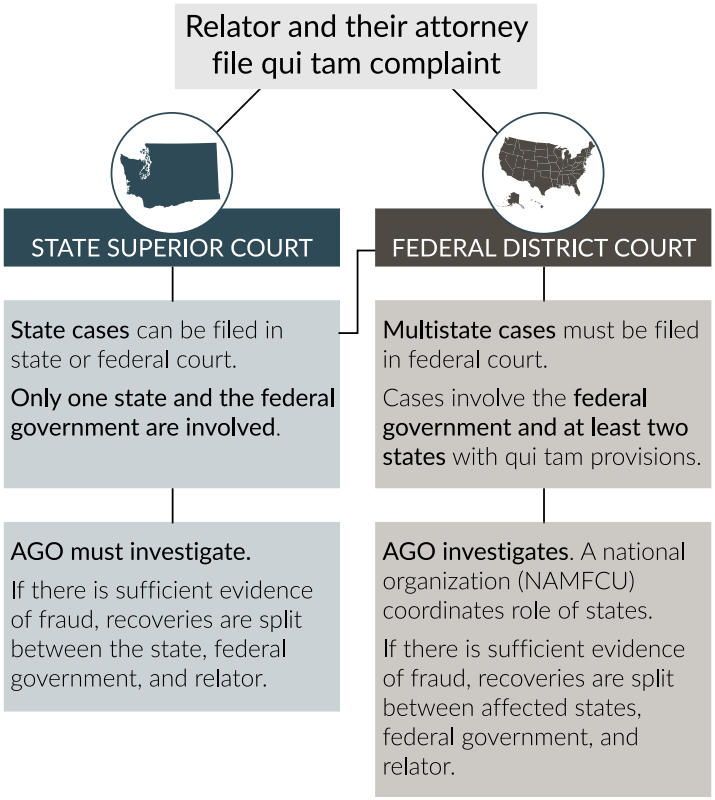
Provider fraud increases Medicaid costs for the state and federal government. Some types of fraud may result in patient harm. Providers that have committed fraud include individual practitioners, Washington companies, and companies that provide services nationally.

Qui tam allows private parties to report Medicaid fraud and receive part of the recoveries

The 2012 Legislature passed the Medicaid Fraud False Claims Act (the Act) to help the state combat Medicaid fraud. The Act allows the AGO to pursue civil legal cases against Medicaid providers. Prior to the Act, the AGO could only pursue criminal cases.

The Act includes qui tam[8] provisions that allow private parties, called relators, to file a fraud complaint in civil court against a Medicaid provider on the state's behalf. Qui tam relators often have first-hand knowledge of potential fraudulent activities and can identify fraud that may not be detected through other means, such as referral from state agencies or criminal proceedings.

Exhibit 1.1. The AGO participates in state and multistate qui tam cases



Source: JLARC staff analysis.

As illustrated in Exhibit. 1.1, a relator can file a claim in state superior court or federal district court. Cases can be state (involving only Washington, or Washington and the federal government) or multistate (involving multiple states and the federal government). The AGO's involvement in multistate cases varies. The level of involvement depends on whether there is a direct link to Washington, such as witnesses or providers located in the state, and whether the AGO joins the national legal team representing states named in the complaint. Only states with qui tam provisions are eligible to participate in multistate cases. The AGO must investigate all state qui tam complaints (See Section 2 for more detail).

If the AGO or court finds sufficient evidence that fraud occurred, the provider pays a financial recovery[9], either through a settlement with the AGO or a court order. The recovery is shared by the state(s), federal government, and relator.

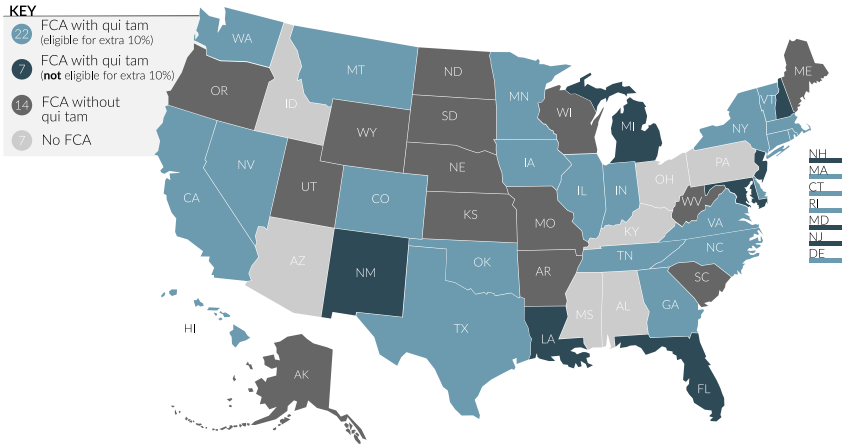
[8]Qui tam originates from a Latin phrase meaning "he who prosecutes for himself as well as the King."
[9]The recovery amount is the financial compensation that the state receives through settlement or court judgment. It may include the amount of fraudulent reimbursement, damages, penalties, and interest.

The federal government and 29 states have qui tam provisions

Forty-three states have False Claims Acts (FCAs). Of these, 29 have an FCA with qui tam provisions. Washington's FCA only applies to Medicaid and not to other state spending programs.

States with FCAs that include qui tam provisions consistent with the federal Deficit Reduction Act (DRA)[10] may receive an additional 10% of the total civil recoveries (see Section 2). Washington is one of 22 states with provisions that meet this requirement.

Exhibit 1.2: Twenty-nine states, including Washington, have qui tam provisions in their False Claims Acts



Source: JLARC staff analysis of National Association of Medicaid Fraud Control Units (NAMFCU) data.

Note: The District of Columbia, Puerto Rico, Guam, and Virgin Islands also have FCAs with qui tam provisions.

The 2016 Legislature extended the sunset date on Washington's qui tam provisions to allow more time for review

When the 2012 Legislature enacted the qui tam provisions, stakeholders expressed concern about the potential for frivolous lawsuits. JLARC's 2015 sunset review of Washington's Medicaid Fraud False Claims Act did not find evidence of frivolous claims, though few qui tam cases had been filed at that time.

Following JLARC's review, the 2016 Legislature extended the sunset date for the qui tam provisions to allow more time for oversight and review. The rest of the Act's provisions were extended without a sunset. The qui tam provisions will sunset on June 30, 2023, unless the Legislature reauthorizes them (RCW 43.131.419).

2. AGO fulfills statutory responsibilities

[10]The 2005 Deficit Reduction Act sought to reduce Medicaid spending and included a financial incentive for states that enact an FCA as strong as the federal law.

The AGO implements the qui tam provisions consistent with statute

RCW 74.66 specifies the roles and responsibilities of the Office of Attorney General (AGO) after a relator files a state qui tam complaint. JLARC staff found that the AGO complies with all statutory roles and responsibilities.

The AGO is also involved in multistate qui tam cases. The level of participation varies by case.

The AGO investigates state qui tam complaints and decides whether to decline or proceed

A standard process is in place for state qui tam cases.

A private party, called a relator, files a complaint in state or federal court. When a person suspects that a Medicaid provider has committed fraud, qui tam provisions allow that person to file a complaint in civil court on the government's behalf. The relator must hire an attorney to file the complaint and the complaint is filed under seal.[11]

The relator serves the AGO with the complaint. The relator must send the complaint to the AGO and provide evidence for the allegation(s).

The AGO investigates. The AGO is required to investigate the complaint within 60 days or request an extension from the court. During the investigation, the AGO looks for evidence that fraud occurred, and that the provider knowingly committed fraud or showed reckless disregard for Medicaid rules and regulations. The AGO considers the following:

- **Do the allegations appear to fall under the legal definition of fraud?** The AGO determines whether the alleged fraud violates Medicaid rules and regulations. In some cases, the relator may observe behavior that they think is suspicious, but the relator may not be aware of the entire situation or all applicable Medicaid rules.
- **How strong is the evidence?** Qui tam cases are civil cases and evidence must meet the standard of "preponderance of evidence."[12] The AGO determines whether there is sufficient evidence to meet that standard and demonstrate that fraud occurred and that the provider knowingly committed fraud.
- **What is the amount of potential recovery?** The AGO weighs whether the amount of the potential recovery[13] exceeds the costs to pursue legal action. Suspected fraud that involves small amounts may be referred to another entity, such as the Health Care Authority or a licensing board, for administrative review.

[11]This means that the case is only disclosable to the court, the relator, the AGO, and the federal government if they are named in the complaint. The provider is not aware of the complaint and does not have access to it while it is under seal.
[12]In a civil case, plaintiffs must meet the burden of proof by providing evidence that a claim is more likely to be true than not true.
[13]The recovery amount is the financial compensation the state receives through settlement or court judgment. It may include the amount of fraudulent reimbursement, damages, penalties, and interest.

- **Was there evidence of patient harm?** If so, the AGO will pursue legal action against the provider even if the recovery amount is small. The case may also be referred for administrative review and/or criminal proceedings.

The AGO decides whether to decline or proceed. At the end of the investigation, the AGO takes one of three actions:

1. **Declines to pursue legal action**. If the investigation does not uncover fraud or sufficient evidence to support the allegations, the AGO will decline to take action against the provider. If the investigation reveals wrongdoing that does not constitute fraud, the AGO may refer the matter to other entities for corrective action. If the AGO declines to take legal action, the relator can proceed with legal action on their own or request case dismissal.
2. **Settles with the defendant**. Litigation is expensive for all parties. If the AGO finds sufficient evidence that fraud occurred, it will try to settle with the provider to obtain a recovery for the state while avoiding costs of pursuing a court case.
3. **Proceeds with litigation ("intervenes").** If a settlement does not occur, the AGO formally intervenes in the case and proceeds with litigation. The AGO has primary responsibility for the case. Cases that go to litigation end when the court makes a ruling or the case settles before trial. If the court rules that the provider committed fraud, the ruling will include a recovery.

Washington splits qui tam recoveries with the federal government and the relator. The state's qui tam provisions result in an additional 10% of recoveries for the state.

If the AGO or court finds sufficient evidence that fraud occurred, the provider pays a financial recovery, either through a settlement with the AGO or a court order. The recovery includes the amount of fraudulent reimbursement, damages, penalties, and interest. Recoveries are shared between the state, federal government, and the relator.

Medicaid costs are shared between the state and federal government. The state and federal government's shares of recoveries are determined by the Medicaid cost-sharing split in place when the fraudulent activity occurred. Washington's qui tam provisions are consistent with the federal Deficit Reduction Act (DRA)[14], allowing the state to receive an additional 10% in all civil recoveries, including multistate and non-qui tam cases. As a result, Washington is entitled to approximately 60% of the recoveries and the federal government receives 40%. The relator's share depends on their level of involvement and can be up to 30% of the state and/or federal government's share.

[14]The 2005 Deficit Reduction Act sought to reduce Medicaid spending and included a financial incentive for states that enact a False Claims Act as strong as the federal law.

Qui tam cases account for 69% of the AGO's civil fraud cases during the study period

During the study period[15], the AGO opened 499 civil Medicaid fraud cases, including 344 qui tam cases. The AGO prioritizes its workload of fraud cases in the following order:

- **State qui tam**. Cases filed by relators that name only Washington's Medicaid Fraud False Claims Act (the Act) in the complaint or name both Washington's Act and the federal False Claims Act (FCA).
- **State non-qui tam**. Cases that the AGO investigates without a relator filing a complaint. The AGO receives fraud referrals from other state agencies, private parties that do not want to be relators, criminal investigations, or other means.
- **Multistate qui tam (also known as global)**. Cases filed by relators naming the federal FCA, Washington's Act and at least one other state's FCA. The cases are filed in a federal court in any state where the provider works. Washington is involved with these cases because of its qui tam provisions. Without the provisions, the state would not participate in cases under seal. The state may receive recoveries if the provider operates in Washington.
- **Multistate non-qui tam**. Washington's AGO and at least one other state and the federal government initiate a case without a relator filing a complaint.
- **National Association of Medicaid Fraud Control Units (NAMFCU)**. Cases in which Washington is not specifically named in the complaint, but is financially affected by the fraud, or cases for which the AGO provides data or assistance to another state or to the federal government.

[15]Federal fiscal years 2016 through 2022. Federal fiscal year 2022 includes eleven months of data, from October 1, 2021 through August 31, 2022.

Exhibit 2.1: Qui tam cases were the most common type of case opened during the study period

Source: JLARC staff analysis of AGO data.

Note: The study period is federal fiscal years 2016 through 2022. Federal fiscal year 2022 includes eleven months of data, from October 1, 2021 through August 31, 2022.

3. Relators filed 19 state qui tam cases

Relators filed 19 state qui tam cases in Washington during the study period

JLARC staff reviewed case files for 19 state cases filed during the study period[16]. These cases involve Washington, and 15 of the 19 included the federal government.

Twelve of the 19 cases have been resolved

As detailed in Exhibit 3.1, 12 of the state cases have been resolved. The Office of the Attorney General (AGO) declined to pursue legal action in eight, settled three, and litigated one. The settled and litigated state cases resulted in recoveries of $22.9 million. As of August 2022, the remaining seven cases were still under seal[17].

Exhibit 3.1: Of the 12 resolved state qui tam cases filed in Washington during the study period, the AGO declined eight, settled three, and litigated one

Case name	AGO action	Description and outcome
State of Washington et al. v. Caregivers Home Health Inc. et al.	Declined	An employee filed a complaint in state court against a home health care agency, alleging fraudulent billing and cost reporting. The investigation did not uncover actions that met the AGO's criteria for proceeding with litigation. The AGO referred the case for administrative review and resolution. The relator voluntarily dismissed the case.
State of Washington et al. v. Centene Corp. et al.	Settled	An attorney with firsthand knowledge filed a complaint in state court alleging fraudulent billing and cost reporting by a Medicaid-contracted managed care organization and the pharmacy benefit manager. The AGO recovered $19,999,999 for the state.

[16]Federal fiscal years 2016 through 2022. Federal fiscal year 2022 includes eleven months of data, from October 1, 2021 through August 31, 2022.
[17]The case is under seal during the AGO's investigation. Only the court, the relator, the AGO, and the federal government (if named) are aware of the case. The provider does not have access to court documents while it is under seal.

Case name	AGO action	Description and outcome
State of Washington et al. v. Relationships Toward Self Discovery, Inc. et al.	Litigated	An employee filed a complaint in state court against a residential facility, alleging fraudulent billing and cost reporting. The AGO recovered $1,674,098 for the state in the court judgment.
United States of America et al. v. A Brief Counseling Center PS et al.	Settled	A contractor filed a complaint in federal court against a mental health facility, alleging billing for services not rendered, duplicate billing, and upcoding[18]. The AGO recovered $83,390 for the state.
United States of America et al. v. Brain	Declined	A colleague filed a complaint in federal court against a dentist, alleging billing for medically unnecessary procedures. The conduct had been addressed administratively prior to the qui tam filing. The relator voluntarily dismissed the case.
United States of America et al. v. Community Health Systems, Inc. et al.	Declined	An employee filed a complaint in federal court against a hospital, alleging kickbacks[19]. The AGO could not substantiate the allegations. The relator voluntarily dismissed the case.
United States of America et al. v. Community Natural Medicine et al.	Declined	An employee filed a complaint in federal court against a tribe and a family practice. The AGO found no Medicaid money was involved in the primary allegations. The relator pursued the case on their own. The court ruled in favor of the provider and ruled that case was clearly frivolous and clearly vexatious. The relator was ordered to pay the defendants' attorney fees.
United States of America et al. v. Franciscan Health System et al.	Declined	A colleague filed a complaint in federal court against a hospital, alleging billing for medically unnecessary procedures. The AGO could not substantiate the allegations. The relator voluntarily dismissed the case.
United States of America et al. v. Providence Health and Services	Settled	A colleague filed a complaint in federal court against a hospital, alleging billing for medically unnecessary procedures. The AGO recovered $1,098,272 for the state.
United States of America et al. v. Sea-Mar Community Health Center	Declined	A relative of a client filed a complaint in federal court against a community health center, alleging overcharging. The AGO could not substantiate the allegations. The relator pursued the case on their own. The court ruled in favor of the provider. The provider requested a determination that the case was clearly vexatious. The court ruled that while case did not have legal merit, it was not clearly vexatious.

[18]Upcoding is a type of fraud in which the provider exaggerates the level of service performed.
[19]Kickbacks are a type of fraud in which the provider receives financial compensation for prescribing certain drugs or making referrals to a particular facility.

Case name	AGO action	Description and outcome
United States of America et al. v. Voto Health Care Inc.	Declined	An employee filed a complaint in federal court against a home health care agency, alleging billing for medically unnecessary procedures, misrepresentation of services provided, billing for services not rendered, and upcoding. The AGO found no Medicaid money involved in the allegations. The relator voluntarily dismissed the case.
United States of America et al. v. Western Washington Medical Group Inc. PS	Declined	An employee filed a complaint in federal court against a medical practice group, alleging misrepresentation of services provided and fraudulent billing. The AGO found no Medicaid funds involved in the allegations. The relator voluntarily dismissed the case.

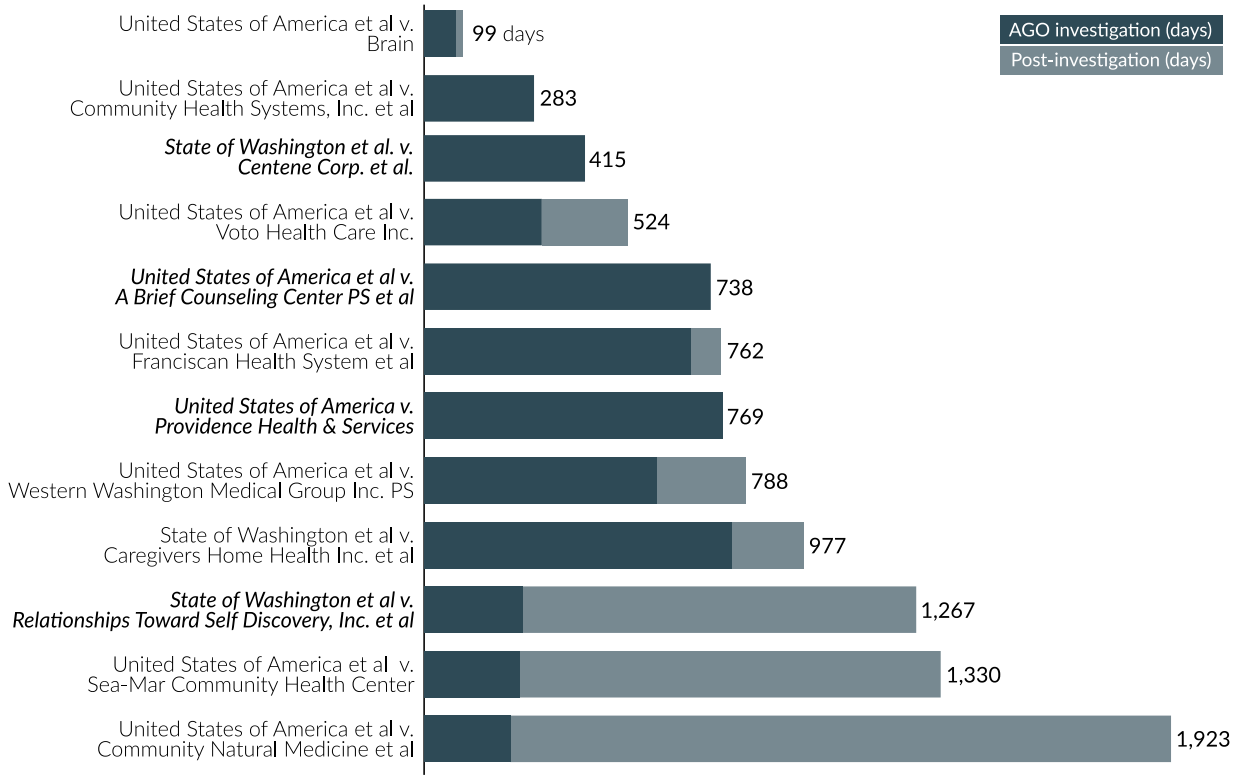
Source: JLARC staff analysis of the AGO data and court documents. Seven other state qui tam cases are under seal.

The median case length was 766 days (2.1 years)

JLARC staff divided cases into two main phases: the AGO investigation phase and post-investigation phase. The length of the AGO investigation varies by case.

- *AGO investigation*: The AGO begins its investigation when it receives a complaint. If the AGO needs longer than 60 days for the investigation, it must file a motion with the court for an extension. To date all investigations have exceeded 60 days. The investigation ends when the AGO files a notice with the court to decline or intervene, or a settlement is reached with the provider. The court seal is often lifted when the AGO makes its decision. For the 12 unsealed cases, the median number of days for the AGO investigation is 359 (ranging from 80 to 792 days). For the seven sealed cases that are still under investigation, the median number of days between the beginning of the AGO's investigation and 8/31/2022 is 708 days (ranging from 434 to 1,402 days).
- *Post-investigation*: After the seal is lifted, the case moves towards resolution (with the exception of settled cases, which are often resolved while the case is under seal). If the AGO pursues legal action, the AGO maintains control of the case. If the AGO declines to pursue legal action, the relator may request a voluntary dismissal or proceed with litigation themselves. For the 12 unsealed cases, the median number of days between when the seal lifted and case resolution is 130 days (ranging from -27 days for a case resolved under seal to 1,701 days).

Exhibit 3.2: Case lengths range from 99 days (0.3 years) to 1,923 days (5.3 years)



Source: JLARC staff analysis. Bold case names indicate the AGO settled with the provider or proceeded with litigation.

One state case was ruled as clearly frivolous during the study period

When the 2012 Legislature enacted the Medicaid Fraud False Claims Act, opponents expressed concerns that the qui tam provisions would lead to numerous frivolous lawsuits. "Frivolous" is not formally defined in statute, but precedent is set through decades of federal case law. Courts ruled that cases are:

- **Clearly frivolous when they are "wholly without merit."** This includes cases with no admissible evidence to support the claim, cases in which the claim is similar to another filed by the same relator and the court already ruled it was without legal merit, or cases with allegations that are not applicable to Medicaid statutes. Cases without legal merit are not automatically considered frivolous. For example, relators may see or experience something that they suspect is fraud, but further investigation may indicate that no fraudulent activity occurred. Cases also may be considered without legal merit when the evidence is insufficient to clearly demonstrate fraud occurred.
- **Clearly vexatious when they are filed with "an improper purpose."** This includes cases that are wholly without merit and the claims appear to be meant to harass or embarrass the provider. In the Washington case, the court described claims against the provider as “scurrilous and potentially damaging to [the provider's] professional reputations.”

The Medicaid provider can file a motion with the court to make a clearly frivolous or clearly vexatious determination if all of the following conditions are met:

- The AGO declines to pursue legal action.
- The relator pursues the case on their own. If the relator voluntarily dismisses the case, it cannot be ruled as clearly frivolous or clearly vexatious.
- The court rules in favor of the provider.

Even if the above conditions are met, courts have indicated that clearly frivolous and clearly vexatious rulings are "reserved for rare and special circumstances."

Steps in the qui tam process may limit potentially frivolous cases

There are checkpoints in the qui tam process to limit potentially frivolous cases:

Relators must hire an attorney. Relators must demonstrate evidence of fraud for an attorney to take the case. Relators' attorneys are often paid only if they win the case, and qui tam cases may take years to resolve.

The AGO controls the trajectory of a case. The AGO controls the investigation while the case is under seal. Two of the AGO's criteria for settling or litigating are whether the claim has legal merit and the strength of the evidence. Of the eight cases the AGO declined, six were voluntarily dismissed by the relator within a few months of the AGO's decision.

Cases are under seal during the AGO's investigation. While under seal, the provider is not aware of the complaint, although they may have to respond to information requests from the AGO. Providers do not accrue significant attorney fees during this phase and information about the case is not available to the public.

Relators are liable for the providers' attorney fees. If a relator continues a case on their own and the court rules the case is clearly frivolous or clearly vexatious, the relator must pay the provider's legal costs.

During the 2015 and 2022 sunset reviews, JLARC staff asked stakeholders if they still had concerns related to the qui tam provisions. Stakeholders did not report any current concerns.

To date, one state case was ruled as clearly frivolous

Of the 12 resolved state cases JLARC staff reviewed, one case was ruled as clearly frivolous.

The case, United States of America et al. v. Community Natural Medicine et al., was filed in federal court and would have occurred with or without the state's qui tam provisions. The case alleged multiple federal False Claims Act violations, including two that involved Medicaid. For one claim, the AGO investigation found the alleged fraudulent behavior did not pertain to Medicaid. For the other claim, the AGO found the alleged violation was a covered service and claims for payment were not fraudulent. The AGO and United States Attorney's Office declined to pursue legal action and the relator continued the case on their own. The provider requested a frivolous and vexatious determination and the court ruled that the relator failed to provide admissible evidence and that the allegations were scurrilous and potentially damaging to the

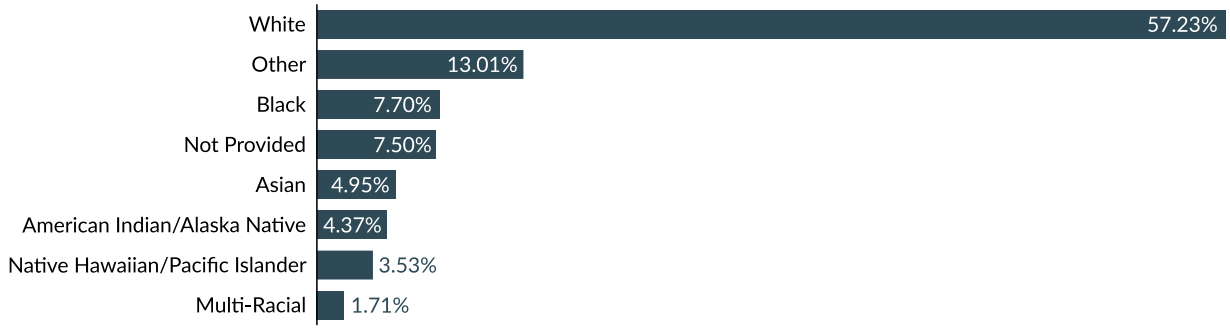
defendants' professional reputations. This resulted in a ruling that the claims were clearly frivolous, clearly vexatious and brought for the primary purpose of harassing and embarrassing the provider. The relator was ordered to pay a portion of the provider's legal fees.

This JLARC assignment included questions about racial equity. However, JLARC staff could not identify whether there were disparate impacts or benefits based on the race of Medicaid providers or patients.

The AGO and the courts do not collect data about the race and ethnicity of relators and providers. Even if such information were available, only 19 qui tam cases were filed in Washington during the study period, which is not a large enough sample size to identify a pattern of impacts.

Some fraud, such as performing and billing for unnecessary procedures or billing for services not provided, may result in patient harm. Patient data was not included in any court documents in the cases JLARC staff reviewed. It is not possible to evaluate whether there would be disparate impacts on Medicaid clients if the qui tam provisions were to sunset. However, the Medicaid system is intended to support disadvantaged populations and fraud affects this system. Forty-three percent of Washington's Medicaid clients identify as non-white (see Exhibit 3.3), however records are not maintained to determine how fraud involving patient harm affects clients by race. Fraudulent activities that could result in patient harm may not be uncovered without the qui tam provisions.

Exhibit 3.3. Racial distribution of Washington's Medicaid clients



Source: Washington Health Care Authority, Apple Health Client Dashboard, May 2022.

4. Recoveries exceed expenditures

During the study period, the AGO spent $4.0 million in state funds and recovered $71.8 million through state and multistate cases

The state and federal government share the costs and recoveries for investigating and litigating Medicaid provider fraud in Washington. During the study period[20], Washington recovered more than it spent.

The federal government covers 75% of the costs for Washington's Medicaid Fraud Control Division

A grant from the U.S. Department of Health and Human Services covers 75% of the state's costs for its Medicaid Fraud Control Division. The Office of the Attorney General (AGO) spent $4.0 million in state funds pursuing civil fraud cases during the study period and the federal grant covered an additional $12.1 million, totaling $16.2 million in expenditures. Costs include the pursuit of both qui tam and non-qui tam cases at the state and multistate level. Washington is eligible for the federal grant regardless of statutory qui tam provisions.

Washington typically keeps 60% of recoveries and returns 40% to the federal government

Because the Medicaid program is a federal-state partnership, both the state and federal government share Medicaid costs and recoveries awarded for fraud cases.

In Washington, Medicaid costs are typically split approximately 50/50 with the federal government based on the Federal Medical Assistance Percentage (FMAP)[21], with some variation each year. The state and federal government share the recoveries using the same percentage split that they used to cover the cost of the fraudulent activities.

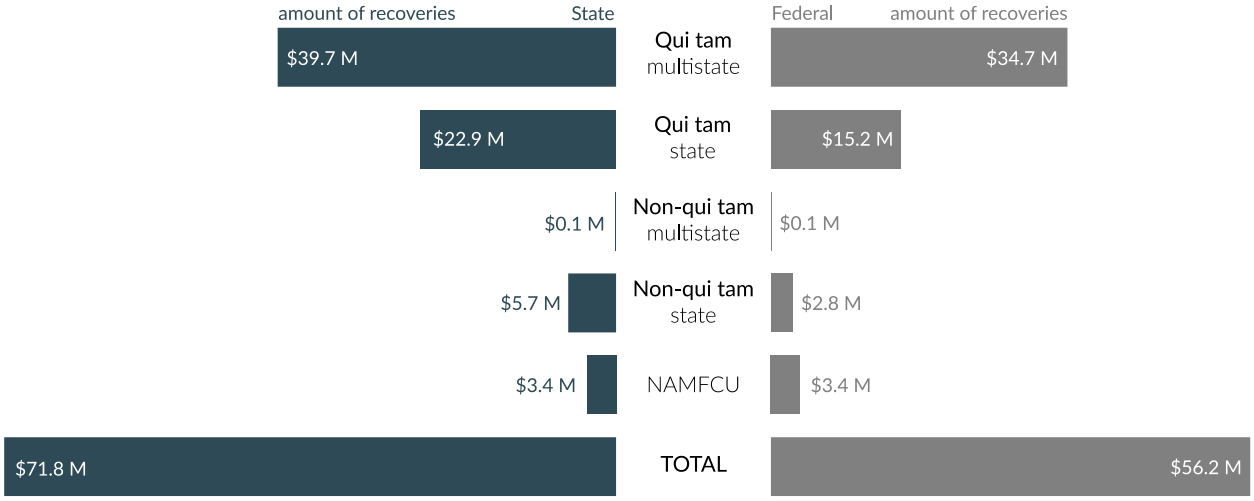
After Washington passed its Medicaid Fraud False Claims Act with qui tam provisions in 2012, the state became eligible for an additional 10% of the total recoveries (see Section 2). This means Washington keeps roughly 60% of recoveries for the state's Medicaid program and the federal government receives 40%.

During the study period, the AGO recovered $71.8 million for the state's Medicaid program and $56.2 million for the federal government. While Washington received 60% of the recoveries for most cases, when all cases were combined the percentage was 56%. Variations in the percentage split between the state and federal government are due to federal policy changes, the time frame for damages awarded in each fraud case, and other federal agreements. The recoveries include

[20]Federal fiscal years 2016 through 2022. Federal fiscal year 2022 includes eleven months of data, from October 1, 2021 through August 31, 2022.
[21]Federal/state cost sharing formula for Medicaid.

qui tam and non-qui tam cases at the state and multistate levels. Qui tam cases make up 87% of all recoveries.

Exhibit 4.1: Multistate qui tam cases generated the majority of state recoveries during the study period



Source: AGO data from federal fiscal years 2016-2022. Federal fiscal year 2022 includes eleven months of data, from October 1, 2021 through August 31, 2022.

The AGO implements the qui tam provisions efficiently and economically, with adequate cost controls

As described in Section 2, the AGO prioritizes qui tam cases over other types of fraud cases and follows a consistent and structured process that weighs the costs of litigation when deciding to decline, settle, or litigate a case. The agency has procedures to monitor spending and staff time through regular supervisory reviews and a required approval process for expenses beyond regular staffing costs. The AGO is subject to annual recertifications and periodic audits by the federal Office of Inspector General.

During the study period, the state's return on investment (ROI) was $17.76 recovered for every dollar spent.

5. Process meets legislative intent

The state's qui tam process works as intended to combat Medicaid fraud and maximize state recoveries

The qui tam process meets legislative intent

The Legislature expressed its intent in two bills[22] regarding the Medicaid Fraud False Claims Act. Exhibit 5.1 highlights how the qui tam process meets legislative intent.

[22]EESB 5978 (2012) and SB 6053 (2018).

Exhibit 5.1: Washington's qui tam provisions meet the Legislature's intent to combat fraud and maximize state recoveries

Legislative intent statement	Met?
Provide the state with **another tool to combat Medicaid fraud**.	**Yes.** Qui tam relators file claims to report potentially fraudulent behavior. If the qui tam provisions sunset, Washington would lose this state-level reporting method and the Office of the Attorney General (AGO) would lose the ability to participate in state and multistate cases filed in federal court.
Root out significant areas of fraud that result in higher health care costs to this state.	**Qui tam contributes.** The AGO reports that qui tam relators report fraud that may be hard to detect otherwise. Some fraudulent behavior can result in patient harm.
Recover state money that could and should be used to support the Medicaid program.	**Yes.** During the study period, Washington's share of qui tam recoveries for state cases was $22.9 million (see Exhibit 4.1). If the qui tam provisions sunset, Washington would not receive recoveries from state cases and would potentially lose recoveries from multistate cases.
Strongly deter Medicaid provider fraud.	**Qui tam contributes.** The existence of the qui tam provisions may serve as a deterrent for Medicaid fraud.
Ensure **maximum recoveries** for the state.	**Yes.** With qui tam provisions in statute, the AGO is eligible to participate in multistate qui tam cases and Washington qualifies for an additional 10% in all civil Medicaid fraud recoveries. The additional 10% resulted in $9.0 million of the $71.8 million recovered during the study period.
Maintain compliance with federal law to receive an additional 10% in civil recoveries.	**Yes.** Compliance is dependent upon having qui tam provisions.
Encourage qui tam whistleblower complaints to at least the same extent as federal False Claims Act (FCA).	**Yes.** The federal FCA includes qui tam provisions. Washington's provisions align with federal provisions.

Source: RCW 74.66.010, RCW 74.66.020, and JLARC staff analysis.

6. Sunset questions answered

Sunset review answers four questions

Question 1: Has the Office of the Attorney General (AGO) implemented the qui tam provisions in a manner consistent with the law and legislative intent?

Yes. The AGO has implemented the qui tam provisions consistent with the law and legislative intent. The AGO developed processes to investigate all state qui tam cases, as required by statute. It participates in multistate cases that involve Washington providers. The AGO decides whether to decline a case or proceed with legal action based on the legal merits of the case, the strength of evidence, the amount of recoveries, and whether there is patient harm. During the study period, the AGO complied with all statutory requirements in Chapter 74.66 RCW.

Question 2: Has the AGO implemented the qui tam provisions in an efficient and economical manner, with adequate cost controls in place?

Yes. The AGO uses a consistent process to prioritize qui tam cases, weighs the costs of litigation when it determines whether to pursue legal action, conducts regular reviews of cases to ensure timely responses, and adheres to statutory timelines. The agency has procedures to monitor its spending and staff time through regular supervisory reviews and a required approval process for expenses beyond regular staffing costs. The AGO is also subject to annual recertifications and periodic audits by the federal Office of Inspector General.

During the study period, the AGO recovered eighteen times more money than it spent for all Medicaid civil fraud cases.

Question 3: Are the AGO's qui tam activities duplicated by another entity or the private sector?

No. There is no public or private entity that duplicates the roles and responsibilities of the AGO in state qui tam cases. While there is potential for duplication in multistate cases, the AGO coordinates with other entities to ensure that its efforts complement, rather than duplicate, those of the other government entities involved.

Question 4: What are the possible effects of eliminating or changing the Medicaid Fraud False Claims Act's qui tam provisions?

Without the qui tam provisions, Washington would lose:

- A method for identifying Medicaid fraud and pursuing a recovery. During the study period, the state recovered $22.9 million in state cases.
- The AGO's ability to participate in state qui tam cases filed in federal court and collect the state's share of recoveries. This is because the federal government does not have direct authority to recover the state's share under Washington's Medicaid Fraud False Claims Act.
- Eligibility for the additional 10% in all civil recoveries. During the study period, the state recovered an additional $9.0 million due to this benefit.

- The ability to participate in multistate cases. AGO participation has allowed the agency to share knowledge and resources with other states and the federal government. Participation helps the AGO identify fraud by providers that are not directly involved in the multistate case. One such case led to a non-qui tam investigation and resulted in a recovery of $1.1 million.

Appendix A: Applicable statutes

RCW 74.66.050, RCW 74.66.060, RCW 74.66.070, and RCW 74.66.080

Qui tam action—Relator rights and duties

RCW 74.66.050

(1) A person may bring a civil action for a violation of RCW 74.66.020 for the person and for the government entity. The action may be known as a qui tam action and the person bringing the action as a qui tam relator. The action must be brought in the name of the government entity. The action may be dismissed only if the court, and the attorney general give written consent to the dismissal and their reason for consenting.

(2) A relator filing an action under this chapter must serve a copy of the complaint and written disclosure of substantially all material evidence and information the person possesses on the attorney general in electronic format. The relator must file the complaint in camera. The complaint must remain under seal for at least sixty days, and may not be served on the defendant until the court so orders. The attorney general may elect to intervene and proceed with the action within sixty days after it receives both the complaint and the material evidence and information.

(3) The attorney general may, for good cause shown, move the court for extensions of the time during which the complaint remains under seal under subsection (2) of this section. The motions may be supported by affidavits or other submissions in camera. The defendant may not be required to respond to any complaint filed under this section until twenty days after the complaint is unsealed and served upon the defendant.

(4) If the attorney general does not proceed with the action prior to the expiration of the sixty-day period or any extensions obtained under subsection (3) of this section, then the relator has the right to conduct the action.

(5) When a person brings an action under this section, no person other than the attorney general may intervene or bring a related action based on the facts underlying the pending action.

[2012 c 241 § 205.]

NOTES:

Sunset Act application: See note following chapter digest.

Intent—Finding—2012 c 241: See note following RCW 74.66.010.

Qui tam action—Attorney general authority

RCW 74.66.060

(1) If the attorney general proceeds with the qui tam action, the attorney general shall have the primary responsibility for prosecuting the action, and is not bound by an act of the relator. The relator has the right to continue as a party to the action, subject to the limitations set forth in subsection (2) of this section.

(2)(a) The attorney general may move to dismiss the qui tam action notwithstanding the objections of the relator if the relator has been notified by the attorney general of the filing of the motion and the court has provided the relator with an opportunity for a hearing on the motion.

(b) The attorney general may settle the action with the defendant notwithstanding the objections of the relator if the court determines, after a hearing, that the proposed settlement is fair, adequate, and reasonable under all the circumstances. Upon a showing of good cause, the hearing may be held in camera.

(c) Upon a showing by the attorney general that unrestricted participation during the course of the litigation by the relator would interfere with or unduly delay the attorney general's prosecution of the case, or would be repetitious, irrelevant, or for purposes of harassment, the court may, in its discretion, impose limitations on the relator's participation, such as:

(i) Limiting the number of witnesses the relator may call;

(ii) Limiting the length of the testimony of the witnesses;

(iii) Limiting the relator's cross-examination of witnesses; or

(iv) Otherwise limiting the participation by the relator in the litigation.

(d) Upon a showing by the defendant that unrestricted participation during the course of the litigation by the relator would be for purposes of harassment or would cause the defendant undue burden or unnecessary expense, the court may limit the participation by the relator in the litigation.

(3) If the attorney general elects not to proceed with the qui tam action, the relator has the right to conduct the action. If the attorney general so requests, the relator must serve on the attorney general copies of all pleadings filed in the action and shall supply copies of all deposition transcripts, at the attorney general's expense. When the relator proceeds with the action, the court, without limiting the status and rights of the relator, may nevertheless permit the attorney general to intervene at a later date upon a showing of good cause.

(4) Whether or not the attorney general proceeds with the qui tam action, upon a showing by the attorney general that certain actions of discovery by the relator would interfere with the attorney general's investigation or prosecution of a criminal or civil matter arising out of the same facts, the court may stay such discovery for a period of not more than sixty days. The showing must be conducted in camera. The court may extend the sixty-day period upon a further showing in camera that the attorney general has pursued the criminal or civil

investigation or proceedings with reasonable diligence and any proposed discovery in the civil action will interfere with the ongoing criminal or civil investigation or proceedings.

(5) Notwithstanding RCW 74.66.050, the attorney general may elect to pursue its claim through any alternate remedy available to the state, including any administrative proceeding to determine a civil money penalty. If any alternate remedy is pursued in another proceeding, the relator has the same rights in the proceeding as the relator would have had if the action had continued under this section. Any finding of fact or conclusion of law made in the other proceeding that has become final is conclusive on all parties to an action under this section. For purposes of this subsection, a finding or conclusion is final if it has been finally determined on appeal to the appropriate court of the state of Washington, if all time for filing the appeal with respect to the finding or conclusion has expired, or if the finding or conclusion is not subject to judicial review.

[2012 c 241 § 206.]

NOTES:

Sunset Act application: See note following chapter digest.

Intent—Finding—2012 c 241: See note following RCW 74.66.010.

Qui tam action—Award—Proceeds of action or settlement of claim

RCW 74.66.070

(1)(a) Subject to (b) of this subsection, if the attorney general proceeds with a qui tam action, the relator must receive at least fifteen percent but not more than twenty-five percent of the proceeds of the action or settlement of the claim, depending upon the extent to which the relator substantially contributed to the prosecution of the action.

(b) Where the action is one which the court finds to be based primarily on disclosures of specific information, other than information provided by the relator, relating to allegations or transactions in a criminal, civil, or administrative hearing, in a legislative or administrative report, hearing, audit, or investigation, or from the news media, the court may award an amount it considers appropriate, but in no case more than ten percent of the proceeds, taking into account the significance of the information and the role of the relator in advancing the case to litigation.

(c) Any payment to a relator under (a) or (b) of this subsection must be made from the proceeds. The relator must also receive an amount for reasonable expenses which the court finds to have been necessarily incurred, plus reasonable attorneys' fees and costs. All expenses, fees, and costs must be awarded against the defendant.

(2) If the attorney general does not proceed with a qui tam action, the relator shall receive an amount which the court decides is reasonable for collecting the civil penalty and damages. The amount may not be less than twenty-five percent and not more than thirty percent of the proceeds of the action or settlement and must be paid out of the proceeds. The relator must also receive an amount for reasonable expenses, which the court finds to have been necessarily

incurred, plus reasonable attorneys' fees and costs. All expenses, fees, and costs must be awarded against the defendant.

(3) Whether or not the attorney general proceeds with the qui tam action, if the court finds that the action was brought by a person who planned and initiated the violation of RCW 74.66.020 upon which the action was brought, then the court may, to the extent the court considers appropriate, reduce the share of the proceeds of the action which the person would otherwise receive under subsection (1) or (2) of this section, taking into account the role of that person in advancing the case to litigation and any relevant circumstances pertaining to the violation. If the person bringing the action is convicted of criminal conduct arising from his or her role in the violation of RCW 74.66.020, that person must be dismissed from the civil action and may not receive any share of the proceeds of the action. The dismissal may not prejudice the right of the state to continue the action, represented by the attorney general.

(4) If the attorney general does not proceed with the qui tam action and the relator conducts the action, the court may award to the defendant reasonable attorneys' fees and expenses if the defendant prevails in the action and the court finds that the claim of the relator was clearly frivolous, clearly vexatious, or brought primarily for purposes of harassment.

(5) Any funds recovered that remain after calculation and distribution under subsections (1) through (3) of this section must be deposited into the medicaid fraud penalty account established in RCW 74.09.215.

[2012 c 241 § 207.]

NOTES:

Sunset Act application: See note following chapter digest.

Intent—Finding—2012 c 241: See note following RCW 74.66.010.

Qui tam action—Restrictions—Dismissal

RCW 74.66.080

(1) In no event may a person bring a qui tam action which is based upon allegations or transactions which are the subject of a civil suit or an administrative civil money penalty proceeding in which the state is already a party.

(2)(a) The court must dismiss an action or claim under this section, unless opposed by the attorney general, if substantially the same allegations or transactions as alleged in the action or claim were publicly disclosed:

(i) In a state criminal, civil, or administrative hearing in which the attorney general or other governmental [government] entity is a party;

(ii) In a legislative report, or other state report, hearing, audit, or investigation; or

(iii) By the news media; unless the action is brought by the attorney general or the relator is an original source of the information.

(b) For purposes of this section, "original source" means an individual who either (i) prior to a public disclosure under (a) of this subsection, has voluntarily disclosed to the attorney general the information on which allegations or transactions in a claim are based, or (ii) has knowledge that is independent of, and materially adds to, the publicly disclosed allegations or transactions, and who has voluntarily provided the information to the attorney general before filing an action under this section.

[2012 c 241 § 208.]

NOTES:

Sunset Act application: See note following chapter digest.

Intent—Finding—2012 c 241: See note following RCW 74.66.010.

RECOMMENDATIONS & RESPONSES
Legislative Auditor Recommendation

The Legislative Auditor makes one recommendation regarding reauthorizing the qui tam provisions of the Medicaid Fraud False Claims Act

Recommendation: Reauthorize the qui tam provisions of the Medicaid Fraud False Claims Act

The Legislative Auditor recommends reauthorizing the qui tam provisions in the Medicaid Fraud False Claims Act and making them permanent because the process meets legislative intent and maximizes recoveries for the state.

Legislation Required:	Yes. Without legislative action, RCW 74.66.050, RCW 74.66.060, RCW 74.66.070, and RCW 74.66.080 will expire on June 30, 2023.
Fiscal Impact:	Maintain current financial recovery efforts, including eligibility to receive an additional 10% in recoveries.
Implementation Date:	2023 Legislative Session
Agency Response:	The AGO and OFM concur with this recommendation.

AGO Response

Bob Ferguson
ATTORNEY GENERAL OF WASHINGTON
Medicaid Fraud Control Division (MFC)
PO Box 40114 • Olympia WA 98504-0114 • (360) 586-8888

October 19, 2022

Mr. Keenan Konopaski, Legislative Auditor
Joint Legislative Audit & Review Committee 106
11th Ave SW, P.O. Box 40910
Olympia, WA 98504-0910

Via E-mail

Re: ***Agency Response to the 2022 Legislative Auditor Recommendations***

Dear Mr. Konopaski,

We very much appreciate the opportunity to respond to the 2022 JLARC Medicaid False Claims Act audit review. As part of our response, we wish to acknowledge the very thorough and highly competent review that Melanie Stidham and Aline Meysonnat conducted. The process was conducted with the utmost independence, rigor, and extreme professionalism.

JLARC Preliminary Report: Medicaid Fraud False Claims Act Sunset Review

Agency Response to the Legislative Auditor Recommendation:

RECOMMENDATION	AGENCY POSITION	COMMENTS
The Legislature should reauthorize the *qui tam* provisions of the Medicaid Fraud False Claims Act and make them permanent.	The Attorney General's Office concurs with this recommendation	The WA-FCA is an essential law enforcement tool in the effort to detect and deter provider fraud in Washington's Medicaid system and to recover taxpayers' dollars lost due to fraud, waste and abuse.

Additional Response:

The WA-FCA *qui tam* provisions are important and effective tools enabling the Attorney General's Office (AGO) to more quickly identify fraud, deter fraud, and recover unlawfully obtained Medicaid funds. These whistleblower provisions directly support the effort to protect the integrity

of the Medicaid system.

The AGO has recovered tens of millions of dollars from Medicaid provider fraud schemes that we would not have uncovered but for the *qui tam* cases. The WA-FCA provides additional benefits beyond these substantial recoveries. Allowing whistleblowers to report suspected fraud to Washington through the WA-FCA is the primary prerequisite allowing the MFC to gain knowledge of sealed *qui tam* cases filed in federal courts, in both state and multi-state cases. These types of cases enable MFC to participate early in multi-jurisdictional ("global") investigations and local federal investigations, which maximizes recoveries for Washington. Knowing about the global cases also allows us to determine whether particular Washington providers, who are not named or specifically identified in the case, may be committing fraud. One case in particular involving now closed Washington pain clinics owned by Dr. Li and operating under the name "Seattle Pain Center" was discovered through a global *qui tam* involving fraudulent urine drug tests. In the course of the investigation, we discovered and alleged fraud against Dr. Li that was resolved through settlement. We also became concerned about patient safety and the number of deaths occurring as a result of seeking care at the clinics. We referred the matter to the Washington State Medical Commission who subsequently took action against many of the providers, and the Washington State Health Care Authority protected Washington residents by terminating the Medicaid provider contract. Had it not been for the global matter, our ability to discover potential harm to patients and the fraud would have taken much longer than it did, or we may not have ever learned about the particular problem.

Importantly, the WA-FCA *qui tam* provisions encourage disclosure of possible fraud to the MFC, which is essential to the mission to *detect and deter* fraud within the Medicaid system. The *qui tam* provisions, like those in its long-standing and successful federal law counterpart, are essential to uncovering sophisticated medical fraud schemes. The value in working alongside our federal partners, and the other states *because we have qui tam provisions* cannot be overstated.

The Legislature's decision to make the non-*qui tam* parts of the WA-FCA permanent in 2016, and to maintain the *qui tam* provisions for further review were sound public policy choices. Making the *qui tam* provisions permanent is also a sound public policy choice. The Attorney General's Office strongly believes that it is vitally important for Washington to have a WA-FCA with *qui tam* provisions. Without these provisions we would lose not only an additional 10% share of any Medicaid recovery, but also an important avenue for reporting fraud, and detecting it in the first instance. We owe it to the residents of Washington to do all that we can to bring integrity and accountability to the expenditure of Washington's Medicaid funds.

Again, thank you for your continuing effort in this important review process.

Larissa U. Payne, Director
Medicaid Fraud Control
Washington State Attorney General's Office

cc: Bob Ferguson

OFM Response

STATE OF WASHINGTON

OFFICE OF FINANCIAL MANAGEMENT

Insurance Building, PO Box 43113 • Olympia, Washington 98504-3113 • (360) 902-0555

October 21, 2022

TO: Keenan Konopaski, Legislative Auditor
Joint Legislative Audit and Review Committee

FROM: David Schumacher
Director

SUBJECT: **RESPONSE ON JLARC SUNSET REVIEW ON MEDICAID FRAUD QUI TAM PROVISIONS**

The Office of Financial Management appreciates the opportunity to review and comment on the Joint Legislative Audit and Review Committee's preliminary report titled "Sunset review of Medicaid Fraud Qui Tam Provisions."

Recommendation	Agency Position	Comments
The Legislative Auditor recommends reauthorizing the qui tam provisions in the Medicaid Fraud False Claims Act and making them permanent because the process meets legislative intent and maximizes recoveries for the state.	Concur	Continuing the qui tam provisions of the Medicaid Fraud False Claims Act will assist in maximizing state recoveries and the efficiency of state funds.

Again, thank you for the opportunity to comment on this preliminary report. Please don't hesitate to contact Jason Brown, Budget Assistant, at (360) 742-7277 with any questions.

cc: Jason Brown, Budget Assistant, OFM
Robyn Williams, Senior Budget Advisor, OFM
K.D. Chapman-See, Legislative Director, OFM
Molly Voris, Senior Policy Advisor, Executive Policy Office
Tammy Firkins, Performance Audit Liaison, Office of the Governor

Current Recommendation Status

JLARC staff follow up on the status of Legislative Auditor recommendations to agencies and the Legislature for four years. The most recent responses from agencies and status of the recommendations in this report can be viewed on our Legislative Auditor Recommendations page.

MORE ABOUT THIS REVIEW
Audit Authority

The Joint Legislative Audit and Review Committee (JLARC) works to make state government operations more efficient and effective. The Committee is comprised of an equal number of House members and Senators, Democrats and Republicans.

JLARC's nonpartisan staff auditors, under the direction of the Legislative Auditor, conduct performance audits, program evaluations, sunset reviews, and other analyses assigned by the Legislature and the Committee.

The statutory authority for JLARC, established in Chapter 44.28 RCW, requires the Legislative Auditor to ensure that JLARC studies are conducted in accordance with Generally Accepted Government Auditing Standards, as applicable to the scope of the audit. This study was conducted in accordance with those applicable standards. Those standards require auditors to plan and perform audits to obtain sufficient, appropriate evidence to provide a reasonable basis for findings and conclusions based on the audit objectives. The evidence obtained for this JLARC report provides a reasonable basis for the enclosed findings and conclusions, and any exceptions to the application of audit standards have been explicitly disclosed in the body of this report.

Committee Action to Distribute Report

On November 30, 2022 this report was approved for distribution by the Joint Legislative Audit and Review Committee. Action to distribute this report does not imply the Committee agrees or disagrees with Legislative Auditor recommendations.

Study Questions

Click image to view PDF of proposed study questions.

Washington JLARC

PROPOSED STUDY QUESTIONS

Sunset Review of Medicaid Fraud Qui Tam Provisions

State of Washington Joint Legislative Audit and Review Committee — UPDATED: April 2022

Medicaid Fraud False Claims Act allows the state to pursue civil penalties for Medicaid provider fraud

In 2012, the Legislature passed the Medicaid Fraud False Claims Act ("the Act", Chapter 74.66 RCW) to help the state combat Medicaid fraud. Medicaid is a federal-state program that funds health care for individuals with low incomes or disabilities.

The Act allows Washington's Attorney General (AGO) to pursue civil penalties against Medicaid providers who file false claims or engage in other forms of fraud. Before the Act passed, the AGO could only investigate criminal cases of fraud.

The Act's qui tam provisions allow private individuals and entities to file civil action on the state's behalf

Private individuals and entities, known as qui tam relators (relators), may file a civil action on behalf of the state for false or fraudulent Medicaid activities. A relator must know of a provider's fraudulent activities, hire an attorney, notify the AGO of the claim, and give the AGO supporting evidence.

The AGO can either intervene or decline involvement in a qui tam case. Either way, the relator will receive a portion of any financial recoveries.

Qui tam provisions will sunset in 2023

When the qui tam provisions first passed, stakeholders expressed concerns about the potential for frivolous lawsuits. JLARC's 2015 sunset review of Washington's Medicaid Fraud False Claims Act did not find evidence of this, though few qui tam cases had been filed at that time.

The 2016 Legislature extended the sunset date on the qui tam provisions to allow more time for oversight and review. The qui tam provisions will sunset on June 30, 2023, unless the Legislature reauthorizes them (RCW 43.131.419).

This study will address the following questions, consistent with the Sunset Act

1. Has the AGO implemented the qui tam provisions in a manner consistent with the law and legislative intent?
    a. What factors does the AGO consider when deciding to intervene or decline in a case?
2. Has the AGO implemented the qui tam provisions in an efficient and economical manner, with adequate cost controls in place?
3. Have any qui tam claims been determined to be frivolous in Washington?
    a. What are the characteristics of the determinations and the parties involved in any frivolous claims?
4. To what extent are the AGO's qui tam activities duplicated by another entity or the private sector?
5. What are the possible effects of eliminating or changing the Act's qui tam provisions, and is there any evidence that these effects could have disparate impacts on Medicaid clients?

JOINT LEGISLATIVE AUDIT & REVIEW COMMITTEE
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PROPOSED STUDY QUESTIONS | Sunset Review of Medicaid Fraud Qui Tam Provisions

In accordance with RCW 44.28.076, JLARC staff determined there are racial equity considerations for this study and they are included in the study questions above.

Study timeframe

Preliminary Report: September 2022 **Proposed Final Report:** November 2022

Study team

Team Lead	Melanie Stidham	(360) 786-5183	Melanie.Stidham@leg.wa.gov
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Legislative Auditor	Keenan Konopaski	(360) 786-5187	Keenan.Konopaski@leg.wa.gov

JLARC Study Process

Methodology

The methodology JLARC staff use when conducting analyses is tailored to the scope of each study, but generally includes the following:

- **Interviews** with stakeholders, agency representatives, and other relevant organizations or individuals.
- **Site visits** to entities that are under review.
- **Document reviews**, including applicable laws and regulations, agency policies and procedures pertaining to study objectives, and published reports, audits or studies on relevant topics.
- **Data analysis**, which may include data collected by agencies and/or data compiled by JLARC staff. Data collection sometimes involves surveys or focus groups.
- **Consultation with experts** when warranted. JLARC staff consult with technical experts when necessary to plan our work, to obtain specialized analysis from experts in the field, and to verify results.

The methods used in this study were conducted in accordance with Generally Accepted Government Auditing Standards.

More details about specific methods related to individual study objectives are described in the body of the report under the report details tab or in technical appendices.

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