Testimony
Engrossed Senate Bill No. 2126 – Department Of Human Services
House Human Services Committee
Representative Clara Sue Price, Chairman
March 14, 2007

Chairman Price, members of the House Human Services Committee, I am Melissa Hauer, an attorney with the Department of Human Services. I am here today to testify in support of engrossed Senate Bill number 2126.

Medicaid is a matching program and improper payments to providers cause unnecessary state and federal expenditures. The federal government pays a share of each state's Medicaid program costs. That share, known as the Federal Medical Assistance Percentage (FMAP), is determined annually by the federal government. The federal government uses the FMAP rate to share in the cost of the state's outlays for covered items and services. When improper payments to a provider are recovered, the state must repay the federal government its percentage share as determined by the FMAP.

The Deficit Reduction Act of 2005 (DRA) [Public Law No. 109-171] allows states that enact a false claims act to keep ten percent of the federal share of any fraudulent payments recovered under that state's false claims act. This incentive was created by Congress to encourage states to establish and maintain laws and standards for the prosecution of false or fraudulent Medicaid claims. The ten percent incentive is available to those states whose false claims acts meet the requirements of the Inspector General of the United States Department of Health and Human Services as set out in the federal False Claims Act.

Currently, the FMAP in North Dakota is 64.72 percent. As the law is today, in a recovery of improperly made Medicaid payments, 64.72 percent of the recovery would have to be returned to the federal government. This bill would allow the state to keep an additional ten percent of the recovery. In other words, instead of keeping only 35.28 percent, the state would be allowed to keep 45.28 percent of any fraud recovery made under this bill.

According to the U.S. Department of Justice, whistleblower actions brought under the federal False Claims Act for fraud against the federal government have returned more than $8.4 billion to the government since Congress amended the False Claims Act in 1986. As you can see from the fiscal note, there is no exact estimate of the amount of improper payments or the percentage of improper payments that are likely fraudulent in North Dakota. The Department's sense is that the vast majority of providers serving North Dakota Medicaid recipients are honest in their billings for Medicaid reimbursement. However, even though we are lucky to have the kind of honest culture that we do, we are not completely immune from the fraudulent practices of a few. The responsibility for detecting, investigating, and prosecuting fraud and abuse in the Medicaid program is the shared responsibility of the federal government and state governments. This bill does not require any particular action to be taken. It merely establishes an additional tool to address suspected fraud in the Medicaid program and it would allow the state to keep more of that recovery.

State false claims legislation requirements. To receive the ten percent incentive share, a state's false claims act must:

1. establish liability to the state for false or fraudulent claims as described in the federal False Claims Act;

2. contain provisions that are at least as effective in rewarding and facilitating *qui tam* actions as those in the federal False Claims Act;

3. contain a requirement for filing an action under seal for 60 days during which time the Attorney General for that state reviews the action; and

4. contain a civil penalty not less than the amount authorized by the Federal False Claims Act.

This bill contains all of these requirements. The bill provides that those who knowingly submit, or cause another person or entity to submit, false claims for payment of Medicaid funds are liable for three times the state's damages plus civil penalties of $5,000 to $10,000 per false claim (which are the amounts required by the federal False Claims Act found at 31 U.S.C. 3729 *et seq*.).

The bill also contains *qui tam*, or whistleblower, provisions. *Qui tam* is a unique mechanism in the law that allows citizens with evidence of fraud against government contractors and programs to sue on behalf of the government to recover the stolen funds. In compensation for the risk and effort of filing a *qui tam* case, the citizen plaintiff (referred to as "private person" in the bill) may be awarded between 15 and 30 percent of the funds recovered. A *qui tam* suit initially remains under seal for at least 60 days during which the Attorney General of the state can investigate the claim and decide whether to join the action. The Attorney General, after investigating the merits of the case, determines whether to

intervene and litigate the case on behalf of the state. If the state decides to intervene, the Attorney General may work cooperatively with the citizen plaintiff but maintains control over the case for the state. The citizen plaintiff is subject to certain limitations in his or her participation in the case. The Attorney General may seek civil penalties for the filing of false or fraudulent Medicaid claims regardless of whether a citizen plaintiff is involved.

If there are any questions, I would be happy to respond to them.

Thank you.