

## ***STATE FALSE CLAIMS ACT SUMMARIES***

As referenced in *Our Values and Ethics at Work Reference Guide*, the following are summaries of the false claims acts and similar laws of the states in which CHI hospitals operate. This list will be updated from time to time as additional states implement such laws.

### **ARKANSAS**

#### ***What is the Arkansas False Claims Act?***

The Arkansas Medicaid Fraud False Claims Act (“AMFFCA”) (Ark. Code Ann. §§ 20-77-901 to 20-77-911) is a civil statute that helps the state combat fraud and recover losses resulting from fraud in the Arkansas Medicaid program. The AMFFCA became effective on April 4, 2011. In addition, Arkansas has a criminal statute, the Arkansas Medicaid Fraud Act (“AMFA”) (Ark. Code Ann. §§ 5-55-101 to 5-55-114), which provides for criminal sanctions in cases of Medicaid fraud. The AMFA became effective on December 31, 2005.

Violations of the AMFFCA include: (1) knowingly making false statements or concealing relevant knowledge related to any benefit or payment under the Medicaid program or to the condition or operation of an entity; (2) knowingly converting a benefit to a use other than for the use and benefit of another person; (3) knowingly presenting a Medicaid claim for a physician's services while knowing that the individual who furnished the service was not licensed as a physician; (4) knowingly soliciting or receiving any remuneration (kickback, bribe, or rebate) in exchange for referrals or recommendations; (5) knowingly charging in excess of the established rates or requiring additional payment as a condition of admission or continued stay; and (6) knowingly participating in the Medicaid program after having been found guilty or pleading guilty or no contest to a Medicaid fraud charge, theft of public benefits, or abuse of adults or employing a person who has abused adults.

Actions that violate the AMFA include the actions (1) through (4) listed above under the AMFFCA except where there is a lower intent standard. A person must act “knowingly” under the AMFFCA in order for a violation to occur. Knowingly means a person has actual knowledge or acts in deliberate ignorance or reckless disregard of the truth. In contrast, the AMFA requires that a person act “purposely,” which means that a person had a “conscious object” to engage in unlawful conduct. In addition, participation in the Medicaid program after being found guilty or pleading guilty or no contest in a Medicaid fraud charge is considered illegal Medicaid participation under the AMFA.

#### ***What are the Qui Tam Provisions and Whistleblower Protections?***

The AMFFCA and AMFA *do not* contain provisions that allow individuals (or *qui tam* plaintiffs) with original information concerning fraud to file a lawsuit on behalf of the state. However, both statutes allow individuals who report fraud to the Arkansas Attorney General to receive up to 10% of the total amount recovered, but in no case no more than \$100,000.

The AMFFCA and AMFA protect individuals who provide records to the state from civil or criminal liability.

Like federal law, the Arkansas Whistle-Blower Act (“Ark. Code. Ann. § § 21-1-601 to 21-1-608) prohibits public employers from discharging, discriminating, threatening or retaliating against public employees because of their: (1) good faith disclosure of information about a waste of public funds, property or manpower, or a suspected violation of a law, rule or regulation; (2) lawful participation in a false claims inquiry or administrative review; or (3) their refusal to assist employers in violating laws such as the Arkansas Medicaid Fraud False Claims Act and the Medicaid Fraud Act. Arkansas law does not appear to contain similar protections for non-public employees.

### ***What are the Penalties?***

A civil action filed under the AMFFCA may not be brought more than five years after the date on which the violation of the Act is committed. Penalties of actual damages, plus a fine of \$5,000 to \$10,000 per claim and treble damages may be imposed for AMFFCA violations. A violator may also be suspended from Medicaid or have its provider agreement revoked. Penalties of full restitution, a mandatory fine of three times the total amount of the false claims, and a fine of up to \$3,000 per claim may be imposed under the AMFA. Violation of the AMFA is also a Class A misdemeanor if the amount of violation is under \$200, a Class C felony if the amount is between \$200 and \$2,500, and a Class B felony if the amount is over \$2,500. Illegal participation in the Medicaid program is a Class A misdemeanor for the first offense, a Class D felony for the second offense and a Class C felony for the third and subsequent offenses.

## **COLORADO**

### ***What is Colorado Medicaid False Claims Act?***

The Colorado Medicaid False Claims Act (“CMFCA”) is a civil statute which is designed to eliminate waste, fraud and abuse in the State’s Medicaid program. (Colo. Stat. Ann. §§ 25.5-4-303.5 to 25.5-4-310). The CMFCA became effective on May 26, 2010.

Violations of CMFCA include: (1) knowingly presenting, or causing to be presented, to an officer or employee of the state a false or fraudulent claim for payment or approval; (2) knowingly making, using, or causing to be made or used a false record or statement material to a false or fraudulent claim; (3) having possession, custody, or control of property or money used, or to be used, by the state in connection with the “Colorado Medical Assistance Act” and knowingly delivering, or causing to be delivered, less than all of the money or property; (4) authorizing the making or delivery of a document certifying receipt of property used, or to be used, by the state in connection with the “Colorado Medical Assistance Act” and, intending to defraud the state, making or delivering the receipt without completely knowing that the information on the receipt is true; (5) knowingly buying, or receiving as a pledge of an obligation or debt, public property from an officer or employee of the state in connection with the “Colorado Medical Assistance Act” who lawfully may not sell or pledge the property; (6) knowingly making, using, or causing to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the state in connection with the “Colorado Medical Assistance Act”, or knowingly concealing or knowingly and improperly avoiding or

decreasing an obligation to pay or transmit money or property to the state in connection with the “Colorado Medical Assistance Act”; and (7) conspiring to commit a violation of any of the acts labeled (1) to (6) above.

Like federal law, the CMFCA includes a civil investigative demand provision. The CMFCA also grants the Colorado Attorney General a broad investigative power to subpoena documents and testimony prior to the filing of a lawsuit.

### ***What are the Qui Tam Provisions and Whistleblower Protections?***

The CMFCA contains provisions that allow individuals (or *qui tam* plaintiffs) to file a lawsuit to enforce the CMFCA on behalf of the state. Once filed, the state may elect to intervene and conduct the lawsuit. If the Attorney General conducts the lawsuit, the *qui tam* plaintiff shall receive between 15% and 25% of the proceeds from the action or settlement of the claim, depending on the extent to which the *qui tam* plaintiff substantially contributed to the prosecution of the action. If the court determines the action is based primarily on disclosures of specific information from hearings, government audits, or from the news media, and not based on information provided by the *qui tam* plaintiff, the court will award the *qui tam* plaintiff no more than 10% of the proceeds from the action or settlement of the claim. If the Attorney General does not conduct the lawsuit, the *qui tam* plaintiff may pursue the lawsuit and, if successful, shall receive between 25% and 30% of the proceeds from the action or settlement, and shall have reasonable and necessary court costs and attorney fees reimbursed by the defendant.

The CMFCA protects employees who are discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in terms and conditions of their employment, because they took lawful steps to disclose information with regard to a CMFCA suit. Such employees are entitled to damages and other relief, including reinstatement with the same seniority status the employee would have had but for the discrimination, twice the amount of back pay, and interest on the pay back, special damages sustained as a result of the discrimination, including litigation costs and reasonable attorney fees. Private actions for retaliation may not be brought more than three years after the date on which the retaliation occurred.<sup>1</sup>

### ***What are the penalties?***

The CMFCA establishes per claim financial penalties of \$5,500 to \$11,000<sup>2</sup>, plus three times the amount of damages that the state sustains because of the act of that violation. In addition, persons found to have violated the CMFCA are liable to the state or to the *qui tam* plaintiff for the costs of the action. If a court finds that the person who committed the violation cooperated with the state investigation of the violation, including furnishing the state with all information known about the violation within 30 days, the court may lower the amount to two times the amount of damages sustained by the state.

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<sup>1</sup> Recently passed legislation amends the CMFCA to make it align with Federal Law.

<sup>2</sup> Recently passed legislation amends the CMFCA to make it align with Federal Law.

## **IDAHO**

### ***What is the Idaho False Claims Act?***

While Idaho does not have a false claims statute that parallels the federal law in structure, Idaho utilizes various rules that collectively accomplishes a similar goal. The Idaho Public Assistance Law (“IPAL”) prohibits providers who contract with the Medicaid program from using fraudulent practices to obtain Medicaid payments to which the provider is not entitled. (Idaho Code Ann. §§ 56-209 (h)(6) to 56-209 (h)(10); 56-227A to 56-227.

A provider engages in fraudulent practices and violates the IPAL when he or she (1) submits a claim with knowledge that the claim is incorrect, including reporting costs as allowable which were known to be disallowed in a previous audit, unless the provider clearly indicates that the item is being claimed to establish the basis for an appeal and each disputed item and amount is specifically identified; (2) submits a fraudulent claim; (3) knowingly makes a false statement or representation of material fact in any document required to be maintained or submitted to the Department of Health and Welfare (the “Department”); (4) submits a claim for an item or service known to be medically unnecessary; (5) fails to provide, upon written request by the department, immediate access to documentation required to be maintained; (6) fails repeatedly or substantially to comply with the rules and regulations governing medical assistance payments or other public assistance program payments; (7) Knowingly violates any material term or condition of its provider agreement; (8) has failed to repay, or was a “managing employee” or had an “ownership or control interest” in any entity that has failed to repay, any overpayments or claims previously found to have been obtained contrary to statute, rule, regulation or provider agreement; or (9) has been found, or was a “managing employee” in any entity which has been found, to have engaged in fraudulent conduct or abusive conduct in connection with the delivery of health care or public assistance items or services.

### ***What are the Qui Tam Provisions and Whistleblower Protections?***

The IPAL laws described above *do not* contain provisions that allow individuals (or *qui tam* plaintiffs) with original information concerning fraud to file a lawsuit on behalf of the state.

However, the Idaho Protection of Public Employees Act prohibits retaliation, discrimination or harassment of employees who report a violation of state law or who cooperate in any investigation of waste of public funds, property or manpower, or a violation of a law or regulation. Idaho law does not contain similar protections for non-governmental employees. (Idaho Code Ann. § 6-2102 to 6-2109).

### ***What are the penalties?***

Violations of IPAL Section 56-209 (h)(6) is a civil violation. Penalties include civil monetary penalties against a provider and any officer, director, owner, and/or managing employee of a provider for a violation. The amount of the penalties shall be up to one thousand dollars (\$1,000) for each item or service improperly claimed, except that in the case of multiple penalties the Department may reduce the penalties to not less than twenty-five percent (25%) of the amount of each item or service improperly claimed if an amount can be readily determined. Each line item of a claim, or cost on a cost report is considered a separate claim. These penalties are intended to be remedial, recovering at a minimum the costs of investigation and administrative review, and placing the costs associated with noncompliance on the offending provider.

Any individual or entity convicted of a criminal offense related to the delivery of an item or service under any state or federal program shall be excluded from program participation as a Medicaid provider for a period of not less than ten (10) years. The Department may exclude any individual or entity for a period of not less than one (1) year for any conduct for which the secretary of the department of health and human services or designee could exclude an individual or entity. The Department may sanction individuals or entities by barring them from public assistance programs for intentional program violations where the federal law allows sanctioning individuals from receiving assistance. Individuals or entities who are determined to have committed an intentional program violation will be sanctioned from receiving public assistance for a period of twelve (12) months for the first violation, twenty-four (24) months for the second violation and permanently for the third violation.

## **IOWA**

### ***What is the Iowa False Claims Act?***

The Iowa False Claims Act (“IFCA”) is a civil statute designed to help the state government combat fraud and recover losses resulting from fraud against public agencies. (Iowa Code §§ 685.1 to 685.7).

Violations of the IFCA include: (1) knowingly presenting or causing to be presented a false or fraudulent claim for payment or approval; (2) knowingly making or using, or causing to be made or used, a false record or statement material to false or fraudulent claim; (3) having possession or control over property or money used, or to be used, by the state and delivering less than all of that money or property; (4) an authorized individual making or delivering a document certifying receipt of property used by the state without completely knowing that the information on the receipt is true; (5) knowingly buying public property from an officer or employee of the state or a member of the Iowa national guard who may not sell or pledge property; (6) knowingly concealing or improperly avoiding or decreasing an obligation to pay or transmit money or property to the state; and (7) conspiring to commit any of the above violations.

### ***What are the Qui Tam Provisions and Whistleblower Protections?***

The IFCA contains provisions that allow individuals (or *qui tam* plaintiffs) to file a lawsuit to enforce the IFCA on behalf of the state. Once filed, the Iowa Attorney General may choose to intervene and conduct the lawsuit. If the Attorney General conducts the lawsuit, the *qui tam* plaintiff shall receive between 15% and 25% of the proceeds from the action or settlement of the claim, depending on the extent to which the *qui tam* plaintiff contributes to the prosecution of the lawsuit. Furthermore, the state has the authority to limit the plaintiff’s participation if it would interfere or unduly delay the state’s prosecution of the case. If the court determines the action is based primarily on disclosures of specific information from hearings, government audits, or from the news media, and not based on information provided by the *qui tam* plaintiff, the court will award the *qui tam* plaintiff no more than 10% of the proceeds from the action or settlement of the claim. If the Attorney General does not conduct the lawsuit, the *qui tam* plaintiff may pursue the lawsuit and, if successful, shall receive between 25% and 30% of the proceeds from the action or settlement, and shall have reasonable and necessary court costs and attorney fees reimbursed by the defendant.

The IFCA protects employees, contractors, or agents who are discharged, demoted, suspended, harassed, or otherwise discriminated against in terms of their employment, because they took lawful acts to stop a violation of the IFCA. Such employees, contractors, or agents are entitled to all relief necessary to make them whole, including reinstatement with the seniority status they would have had, two times the amount of back pay, interest on the back pay, and compensation for any special damages sustained as a result of the discrimination. A civil action under the IFCA may not be brought more than three years after the date when the retaliation occurred.

***What are the Penalties?***

The IFCA establishes financial penalties of \$5,000 to \$10,000 for each violation plus three times the amount of damages sustained by the state as a result of the violation. In addition, persons found to have violated the IFCA are liable to the state or to the *qui tam* plaintiff for the costs of the action. If a court finds that the person who committed the violation cooperated with the state investigation of the violation, including furnishing the state with all information known about the violation within 30 days, the court may lower the amount to two times the amount of damages sustained by the state.

**KANSAS**

***What is the Kansas False Claims Act and the Kansas Medicaid Fraud Control Act?***

The Kansas False Claims Act (“KFCA”) is a civil statute which is designed to help the state government combat fraud and recover losses resulting from fraud against the state, or any political subdivision of the state. (Kan. Stat. Ann. § § 75-7501 to 75-7511). The KFCA became effective on April 30, 2009. In addition, Kansas has a Medicaid Fraud Control Act (“KMFCFA”) which became effective on July 1, 2011 (Kan. Stat. Ann. § 21-5925-5934; 75-725; 75-726).

Violations of the KFCA include: (1) knowingly submitting a false or fraudulent claim for payment or approval to any recipient of State or local funds; (2) knowingly making or using a false record to get a false claim paid; (3) making or using a false record to avoid payments owed to the state government or a political subdivision of the state; (4) delivering less property or money to the state government or a political subdivision of the state than the amount for which the person receives a certificate or receipt; (5) knowingly making or delivering a receipt that falsely represents the property received by the state government or a political subdivision of the state; (6) knowingly buying or receiving public property from any person who is not allowed to sell or pledge the property; (7) failing to disclose and arrange for repayment of a false claim when the person who discovers the falsity of the claim is a beneficiary; and (8) conspiring to commit any of the actions (1) through (7) listed above.

Violations of the KMFCFA include making a false claim, statement or representation to the Medicaid program, with intent to defraud, making, presenting, submitting, offering or causing to be made (1) any false or fraudulent claim for payment for any goods, service, item, or facility accommodation; (2) any false or fraudulent statement or representation for use in determining payments which may be made under Medicaid; (3) any false or fraudulent report or filing which is or may be used in computing or determining a rate of payment for any goods, service, item or facility or accommodation, (4) any false or fraudulent statement or representation made in connection with any report or filing which is or may be used in computing or determining a rate of payment for any goods, service, item, facility or accommodation reimbursable by Medicaid;

(5) any statement or representation for use by another in obtaining any goods, service, item, facility or accommodation reimbursable by Medicaid, knowing the statement or representation to be false; (6) any claim for payment, for any goods, service, item, facility, or accommodation, which is not medically necessary in accordance with professionally recognized parameters for which payment may be made under Medicaid; (7) any wholly or partially false or fraudulent book, record, document, data or instrument, which is kept as documentation or provided to a government official in connection with an ongoing investigation for any goods, service, item, facility or accommodation or of any cost or expense claimed for reimbursement for any goods, service, item, facility or accommodation reimbursable by Medicaid; and (8) any false or fraudulent statement or representation made with the intent to influence any acts or decision of any official, employee or agent of a state or federal agency having regulatory or administrative authority over the Kansas Medicaid program.\*

### ***What are the Qui Tam Provisions and Whistleblower Protections?***

The KFCA *does not* contain provisions that allow individuals (or *qui tam* plaintiffs) with original information concerning fraud to file a lawsuit on behalf of the state. A portion of the proceeds obtained from successful actions is remitted to the defrauded entity, and the remaining proceeds are retained by the State or used to refund money falsely obtained from the Federal government.

The KFCA protects employees who assist the state in taking action under the KFCA from retaliation, and entitles them to all relief necessary to make them whole.

### ***What are the Penalties?***

In addition to any other remedies that may be prescribed by law, a person who violates the KFCA will be liable for (1) a civil penalty of \$1,000 to \$11,000 per claim, (2) damages in the amount of three times the amount of the false claim, and (3) the state's reasonable costs and attorney fees for the civil action brought to recover penalties or damages. Liability under the KFCA is joint and several for any act committed by two or more persons. The courts must reduce damages for violations if the false claims are voluntarily disclosed.

A violation of Subsections (1)-(7) of the KMFCA\*\* is classified: (i) a severity level 7, nonperson felony if the payments illegally claimed are \$25,000 or more; (ii) a severity level 9 nonperson felony if the payments illegally claimed are between \$1,000 and (iii) \$25,000; and a class A misdemeanor if the payments illegally claimed are less than \$1,000. A violation of the KMFCA subsection (8) is classified a severity level 9, nonperson felony.\*\*\*

\*Kansas recently passed legislation in April of 2014 that would slightly alter the language and classification of Kan. Stat. Ann. § 21-5927 (Kansas Medicaid Fraud Control Act ("KMFCFA")). In addition, the legislation adds a section to the definition of Medicaid fraud that any wholly or partially false or fraudulent book, record, document, data or instrument to any properly identified law enforcement officer, any properly identified employee or authorized representative of the attorney general, or to any properly identified employee or agent of the department of social and rehabilitation services, or its fiscal agent, in connection with any audit or investigation involving any claim for payment or rate of payment for any goods, service, item, facility or accommodation payable, in whole or in part, under the Medicaid program. The proposed

legislation would also add another category that constitutes Medicaid fraud as: (2) intentionally executing or attempting to execute a scheme or artifice to defraud the Medicaid program or any contractor or subcontractor of the Medicaid program.

\*\*This legislation would amend the KMFCFA classifications above and additionally include “in addition to other criminal penalties provided by law, any person convicted of a violation of the [KMFCFA] shall, upon request of the Attorney General at any time prior to sentencing, be subject to a fine of not less than \$1,000 and not more than \$11,000 for each violation of such act.”

\*\*\*Additionally, the legislation amends the violation classifications to provide for harsher security levels. For instance: where the aggregate amount of payments illegally claimed is: (A) \$250,000 or more, Medicaid fraud is a severity level 3, nonperson felony; (B) at least \$100,000 but less than \$250,000 Medicaid fraud is a severity level 5, nonperson felony; (C) at least \$25,000 but less than \$100,000, Medicaid fraud is a severity level 7, nonperson felony; (D) at least \$1,000 but less than \$250,000, Medicaid fraud is a severity level 9, nonperson felony; and (E) less than \$1,000, Medicaid fraud is a class A nonperson misdemeanor.

The legislation also adds additional penalties when great bodily harm results from a False Claims Act violation. When great bodily harm results from a False Claims Act violation, regardless of the aggregate amount of the payments illegally claimed, the Medicaid fraud is a severity level 4, person felony. When death results from such act, regardless of the aggregate amount of payments illegally claimed, Medicaid fraud is a severity level 1, person felony. 2013 Kansas Senate Bill No. 271, Kansas Eighty-Fifth Legislature 2014 Regular Session, 2013 Kansas Senate Bill No. 271, Kansas Eighty-Fifth Legislature 2014 Regular Session

## **KENTUCKY**

### ***What is the Kentucky Control of Fraud and Abuse Act?***

The Kentucky Control of Fraud and Abuse Act (“KCFA”) became effective on June 20, 2005 (Ky. Rev. Stat. §§ 205.8451 to 205.8483) and is aimed at providers who submit claims for payment which they are not entitled. The KCFA utilizes both civil and criminal penalties to deter violations.

Violations of the KCFA include: (1) knowingly or wantonly devising a scheme, entering into an agreement, or conspiring to obtain payments from medical assistance programs by means of false claims, reports or documents submitted to health and family services, or intentionally engage in conduct which advances the scheme or artifice; (2) intentionally, knowingly, or wantonly falsifying information used in determining rights to any benefit or payment; (3) misrepresenting the conditions or operations of a facility to qualify as a certified institution; and (4) knowingly falsify, conceal, or cover up by any trick, scheme, or device a material fact, or make any false, fictitious, or fraudulent statement or representation, or make or use any false writing or document knowing the same to contain any false, fictitious, or fraudulent statement or entry.

### ***What are the Qui Tam Provisions and Whistleblower Protections?***

The KCFA *does not* contain provisions that allow individuals (or *qui tam* plaintiffs) with original information concerning fraud to file a lawsuit on behalf of the state. However, like the federal act, the Kentucky Attorney General may commence proceedings to enforce the KCFA.

The KCFA includes special whistleblower protection to protect employees who report or testify regarding potential violations of the KCFA from discharge, discrimination, or retaliation.

Additionally, the KCFA has a mandatory reporting provision which requires any person who knows or has reasonable cause to believe a violation of the KCFA has occurred, to report the information to the Kentucky Medicaid Fraud Control Unit or Hotline.

### ***What are the Penalties?***

The criminal penalties for violating the KFCA include the following: A provider who violates subsections (1) and (2) are guilty of a Class A misdemeanor. However, in the event that the sum of all the benefits or payments claimed reaches three hundred dollars (\$300), the violation is classified Class D felony. Further, a provider who violates subsection (3) is guilty of a Class C felony. Lastly, any provider who violates the provisions of subsection (4) is guilty of a Class D felony.

The civil penalties for violating the KFCA include the following: (1) restitution; (2) up to three times the amount of the excess payments; (3) \$500 fine for each fraudulent claim submitted; and (4) payment of legal, investigation, and enforcement fees.\* Additionally, violators may face removal as a participating provider in the Medical Assistance Program.

\*Recently proposed amendments to KRS 205.8467 would increase the fines for each fraudulent payment submitted. The increases would be equal to: (3) five thousand five hundred dollars (\$5,500) to eleven thousand dollars (\$11,000) for each false or fraudulent claim submitted for providing treatment, services or goods. In addition, the amendment to KRS 205.8467 adds a section (2) which states that liability for damages established under sections 1 to 9 of the act shall take priority and offset any liability for similar damages or penalties under this section. Additionally, an administrative action under this section may be stayed during the pendency of a civil action brought under sections (1) through (9) of the act.

## **MARYLAND**

### ***What is the Maryland False Health Claims Act?***

The Maryland False Health Claims Act (“MFHCA”) is a civil statute designed to help Maryland combat fraud and recover losses resulting from fraud against a state health plan or state health program. (MD. Code Ann., Health-Gen. §§ 2-601 to 2-611). The MFHCA became effective on October 1, 2010. In addition, Maryland provides for criminal penalties in the event a person commits Medicaid Fraud (Md. Code Ann., Crim. Law § 8-508 to § 8-519). The Medicaid Fraud provisions became effective on October 1, 2002.

Violations of MFHCA include: (1) presenting or causing to be presented a false or fraudulent claim for payment or approval; (2) making or using, or causing to be made or used, a false record or statement material to a false or fraudulent claim; (3) conspiring to commit a violation under MFHCA; (4) delivering or causing to be delivered to the state less than all the money or property

to be used by or on behalf of the state under a state health plan or state health program; (5) defrauding the state by preparing or delivering a document certifying receipt of money or other property used or to be used by the state under a state health or a state health program that falsely represents the money or property delivered; (6) buying public property from an officer or employee of the state health plan or state health program who lawfully may not sell the property; (7) making or using, or causing to be made or used, a false record or statement material to an obligation to pay the state or local government; (8) concealing or improperly avoiding or decreasing an obligation to pay or transmit money or other property to the state; or (9) making any other false or fraudulent claims against a state health plan or a state health program.

Violations of the Medicaid Fraud laws include defrauding state health plans by: (1) knowingly and willfully defrauding or attempt to defraud a State health plan in connection with the delivery of or payment for a health care service; (2) knowingly and willfully obtaining or attempt to obtain by means of a false representation money, property, or anything of value in connection with the delivery of or payment for a health care service that wholly or partly is reimbursed by or is a required benefit of a state health plan; (3) knowingly and willfully defrauding or attempt to defraud a state health plan of the right to honest services; or (4) with the intent to defraud making a false representation relating to a health care service or a state health plan. Further, a violation of the Medicaid Fraud laws includes a false representation for qualification by knowingly and willfully making, causing to be made, inducing, or attempt to induce the making of a false representation with respect to the conditions or operation of a facility, institution, or state health plan in order to help the facility, institution, or State health plan qualify to receive reimbursement under a state health plan.

### ***What are the Qui Tam Provisions and Whistleblower Protections?***

The MFHCA contains provisions that allow individuals (or *qui tam* plaintiffs) to file a lawsuit to enforce MFHCA in the name of the State. However, the State must choose whether to intervene and continue the lawsuit once a complaint is filed. If the State declines to join a case initiated by a relator, the case must be dismissed and there are no relator's rights under the statute. Also, the State may withdraw after initially intervening, and the case must then also be dismissed. Awards when the Government does intervene are between 15% and 25%. Specified government employees may not bring a claim based on information they learned in their official capacity. If the State chooses not to intervene, the action will be dismissed. If the State chooses to intervene, it will conduct the lawsuit, and, if successful, the *qui tam* plaintiff will receive between 15% and 25% of the proceeds of any recovery or settlement, based on the *qui tam* plaintiff's contribution to the action.

MFHCA protects employees against retaliatory actions because they took lawful actions in furtherance of an investigation of a potential MFHCA action. Such lawful actions include disclosing or threatening to disclose what the employee reasonably believes is a violation, providing information or testifying regarding an alleged violation, or objecting to or refusing to participate in an activity the employee reasonably believes is a violation. Affected employees may be entitled to reinstatement to the same seniority status and with full fringe benefits and seniority rights, two times the amount of lost wages, benefits, and other remuneration, including interest, payment of reasonable attorneys costs, an injunction against continued violation, punitive damages and the assessment of a civil penalty of up to \$1000 for the first violation and up to \$5000 for subsequent violations.

### ***What are the Penalties?***

MFHCA establishes financial penalties of up to \$10,000 for each violation (but it may not exceed the total amount of damage incurred by the state health plan or state health program) plus up to three times the amount of damages sustained by the state or local government as a result of the violation. In addition, persons found to have violated MFHCA may be liable for the costs of the action.

Penalties under the Medicaid Fraud laws can be triggered if the value of the money, health care services, or other goods or services involved is \$500<sup>3</sup> or more in the aggregate. In this case, a convicted person will be guilty of a felony and on conviction will be subject to imprisonment not exceeding 5 years, or a fine not exceeding \$100,000 or both. However, a person who violates any other provision of the Medicaid Fraud laws is guilty of a misdemeanor and on conviction is subject to imprisonment not exceeding 3 years or a fine not exceeding \$50,000 or both.

A business entity violating the Medicaid Fraud laws is subject to a fine not exceeding: (i) \$250,000 for each felony; and (ii) \$100,000 for each misdemeanor.

## **MINNESOTA**

### ***What is the Minnesota False Claims Against the State Act?***

The Minnesota False Claims Against the State Act (“MFCASA”) is a civil statute designed to help Minnesota combat fraud and recover losses resulting from fraud. (Minn. Stat. §§ 15C.01 to 15C.16). The MFCASA became effective on July 1, 2010.

Violations of the MFCASA include: (1) knowingly presenting or causing to be presented a false or fraudulent claim<sup>4</sup> for payment or approval to an officer or employee of the state or local government; (2) knowingly making or using, or causing to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the state or local government; (3) knowingly conspiring to either present a false or fraudulent claim to the state or political subdivision or to make or use a false record or statement to get a false or fraudulent claim approved by the state or local government; (4) has possession, custody or control of public property or money used, or to be used, by the state or a political subdivision and knowingly delivering or causing to be delivered to the state or political subdivision less money or property than the amount stated on the receipt; (5) is authorized to prepare or deliver a receipt that falsely represents the money or property delivered to the state or political subdivision; (6) knowingly buying public property from an officer or employee of the state or political subdivision who lawfully may not sell or pledge the property; and (7) knowingly making or using a false record or statement to conceal, avoid, or decrease an obligation to pay the state or political subdivision.<sup>5</sup>

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<sup>3</sup> Recently enacted legislation amends this amount to \$1,000 effective October 1, 2013.

<sup>4</sup> Proposed legislation would amend the definition of “claim”.

<sup>5</sup> Language effective until August 1, 2013; proposed legislation would amend this statute effective August 1, 2013.

***What are the Qui Tam Provisions and Whistleblower Protections?***<sup>6</sup>

The MFCASA contains provisions that allow individuals (or *qui tam* plaintiffs) to file a lawsuit to enforce the MFCASA on behalf of the state or the local government. Once filed, the Minnesota Attorney General or an attorney for a city or county may choose to intervene and conduct the lawsuit. If an attorney for a government entity conducts the lawsuit, the *qui tam* plaintiff shall receive between 15% and 25% of the proceeds of any recovery, in proportion to which the *qui tam* plaintiff's contribution to the action. If the *qui tam* plaintiff conducts the lawsuit, he or she will receive between 25% and 30% of any recovery, as the court determines reasonable. If an attorney for the government does not intervene in the lawsuit at the outset but intervenes subsequently, the *qui tam* plaintiff may receive between 15% and 30% of any recovery. In addition, the court may require the defendant to pay reasonable costs, attorney fees, and expert consultant fees to the *qui tam* plaintiff.

The MFCASA protects employees who are discharged, demoted, suspended, threatened, harassed, denied promotion, or otherwise discriminated against in terms of their employment, because they took lawful steps to disclose information with regard to a MFCASA suit or to bring or testify in such a suit. Such employees are entitled to damages and other relief, including reinstatement, twice the amount of lost compensation, interest on lost compensation, special damages sustained as a result of the discrimination, and, if appropriate, punitive damages.

***What are the Penalties?***

The MFCASA establishes financial penalties of \$5,500 to \$11,000 for each violation plus three times the amount of damages sustained by the state or political subdivision as a result of the violation. In addition, persons found to have violated the MFCASA may be liable to the state or to the *qui tam* plaintiff for the costs of the action. If a court finds that the person who committed the violation cooperated with the state investigation of the violation, including furnishing the state with all information known about the violation within 30 days, the court may lower the amount to two times the amount of damages sustained by the state.

**MISSOURI**

***What is the Missouri Health Improvement Act?***

The Missouri Health Improvement Act ("MHIA") (Mo. Stat. Ann. Chapter 191, §§ 191.900 to 191.910) is a comprehensive healthcare bill, which includes provisions designed to help the State combat fraud and abuse in the Missouri Medicaid program. The MHIA became effective on November 1, 2007.

Violations of the MHIA include: (1) knowingly making or causing to be made a false statement or false representation of a material fact to receive payment; (2) knowingly presenting a claim that falsely represents the service was medically necessary; (3) knowingly concealing the occurrence of any event affecting a right to have payment made; (4) knowingly concealing or

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<sup>6</sup> Proposed language would include a mandatory dismissal provision in enumerated circumstances and add a new section relating to relief from retaliatory actions.

failing to disclose information with the intent to obtain payment in an amount greater than that which the provider is entitled; and (5) knowingly representing a claim that falsely indicates health care was provided where the service provided was of lesser value than described in the claim.

***What are the Qui Tam Provisions and Whistleblower Protections?***

The MHIA *does not* contain provisions that allow individuals (or *qui tam* plaintiffs) with original information concerning fraud to file a lawsuit on behalf of the State. However, the statute allows an individual who is the original source of information used by the Missouri Attorney General to bring a Medicaid fraud action to receive up to 10% of any recovery unless he or she participated in the fraud.

The MHIA protects employees who suffer discrimination as a result of reporting fraud or abuse under the MHIA and entitles them to: (1) reinstatement with the same seniority status, (2) two times the amount of back pay, and (3) interest on the back pay.

***What are the Penalties?\****

A person who violates the MHIA fraud and abuse provisions is liable for both criminal and civil penalties. The criminal penalties include (1) classification as a Class C felony upon the first conviction and referral to the HHS Office of Inspector General; (2) classification as a Class B felony upon the second or subsequent convictions and referral to the HHS Office of Inspector General; (3) classification as a class D felony for any person who willfully prevents, obstructs, misleads, delays, or attempts to prevent, obstruct, mislead, or delay the communication of information or records. The civil penalties include a fine of \$5,000 to \$10,000 for each separate act plus three times the amount of damages that the State sustains because of the violations. Damages may be reduced to no less than two times the damages if the court finds certain mitigating factors that relate to a person's cooperation during the investigation.

In addition to any fines, penalties, or sentences imposed by law, a person will be required to make restitution to the federal and State governments, in an amount at least equal to that unlawfully paid to or by the person and be liable for reasonable investigation and prosecution expenses.\*\*

\*Enacted legislation amends the organization of criminal penalties associated with a MHIA violation. Section 191.905 has been amended to state that those guilty of Sections (1) through (3) are guilty of a class D felony upon his or her first offense. Additionally, 191.914 has been amended to state that any person who intentionally files a false report is guilty of a class E felony on a second or subsequent violation. Additionally, any person who receives compensation in exchange for knowingly failing to report any violation of subsections 1-3 of Section 191.905 is guilty of a class E felony.

\*\*Proposed legislation in the House of Representatives would eliminate the two-year statute of limitations to actions brought under the MHIA.

## **NEBRASKA**

### ***What is the Nebraska False Medicaid Claims Act?***

The Nebraska False Medicaid Claims Act (“FMCA”) is a state law that is designed to provide for the investigation and prosecution of Medicaid fraud. The FMCA sets forth civil penalties for Medicaid fraud and establishes a Medicaid fraud control unit under the Nebraska Attorney General. (Neb. Rev. Stat. Ann. §§ 68-934 to 68-947). The FMCA became effective on May 30, 2009.

Violations of the FMCA include: (1) knowingly presenting or causes a false or fraudulent claim for payment or approval claim<sup>7</sup>, (2) knowingly makes, uses or causes to be made or used, a false record or statement material<sup>8</sup> to a false or fraudulent claim, (3) conspiring to commit a violation of the FMCA (4) having possession, custody, or control of property or money used or to be used by the state and knowingly delivers, or causes to be delivered, less than all of the money or property; (5) is authorized to make or deliver a document certifying receipt of property used, or to be used, by the state and, intending to defraud the state, makes or delivers the receipt knowing that the information on the receipt is not true; (6) knowingly buys or receives as a pledge of an obligation or debt, public property from any officer or employee of the state who may not lawfully sell or pledge such property; or (7) knowingly makes, uses or causes to be made or used, a false record or statement material<sup>9</sup> to an obligation to pay or transmit money or property to the state or knowingly conceals, avoids, or decreases an obligation to pay or transmit money or property to the state.<sup>10</sup>

There are additional actions that are violations of the FMCA, including: (1) failure of a beneficiary to report an inadvertent submission of a false Medicaid claim within sixty days of the discovery that the claim is false, (2) charging, soliciting, accepting, or receiving anything of value in addition to the amount legally payable under the Medicaid program in connection with delivery of a good or service, knowing that such charge, solicitation, acceptance, or receipt is not legally payable, and (3) knowingly failing to maintain the required records for a period of at least six years after the date on which payment was received or knowingly destroying such records within six years from the date payment was received.

The FMCA applies only to Medicaid claims.

### ***What are the Qui Tam Provisions and Whistleblower Protections?***

The FMCA *does not* contain provisions that allow individuals (or *qui tam* plaintiffs) with original information concerning fraud to file a lawsuit on behalf of the state.

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<sup>7</sup> Recently enacted legislation redefines “claim”

<sup>8</sup> Recently enacted legislation adds a new term, “material,” as “having a natural tendency to influence or be capable of influencing the payment or receipt of money or property”.

<sup>9</sup> Recently enacted legislation adds a new term, “material,” as “having a natural tendency to influence or be capable of influencing the payment or receipt of money or property”.

<sup>10</sup> Recently enacted legislation changes the conditions that trigger a false Medicaid claim and impose civil liabilities.

### ***What are the penalties?***

In addition to any other remedies that may be prescribed by law, a person who violates the FMCA will be liable for (1) a civil penalty of not more than ten thousand dollars (\$10,000), (2) damages in the amount of three times the amount of the false claim, and (3) the state's costs and attorney's fees for the civil action brought to recover penalties or damages. Liability under the FMCA is joint and several for any act committed by two or more persons. The courts can reduce damages for violations to two times the amount of the false claim if they are voluntarily disclosed.

## **NEW JERSEY**

### ***What is the New Jersey False Claims Act & Health Care Claims Fraud Act?***

The New Jersey False Claims Act (“NJFCA”) (N.J. Stat. Ann. Title § § 2A:32C-1 et seq.) is a civil statute that helps the State combat fraud and recover losses resulting from fraud in the New Jersey Medicaid program. The NJFCA became effective on March 13, 2008. Additionally, New Jersey amended its Code of Criminal Justice to specifically address “health care claims fraud” committed by practitioners or other individuals. The New Jersey Health Care Claims Fraud (“NJHCCF”) (N.J. Stat. Ann. § 2C:21-4.2 et seq.) provisions became effective on January 4, 2006. Violations of a NJHCCF crime are greater in scope and carry more severe criminal penalties than the civil statute.

Violations of the NJFCA include: (1) knowingly presenting or causing to be presented to an employee, officer, or agent of the State, or to any contractor, grantee, or other recipient of State funds, a false or fraudulent claim for payment or approval; (2) knowingly making, using, or causing to be made or used a false record or statement to get a false or fraudulent claim paid or approved by the State; (3) conspiring to defraud the State by getting a false or fraudulent claim allowed or paid by the State; (4) knowingly delivering or causing to be delivered less public property or money to the State than the amount for which the person receives a certificate or receipt; (5) knowingly making or delivering a receipt for property without completely knowing that the information on the receipt is true; (6) knowingly buying or receiving as a pledge of an obligation or debt, public property that a person may not lawfully sell or pledge; and (7) knowingly making or using or causing to be made or used a false, misleading or fraudulent record or statement to conceal, avoid, or decrease an obligation to pay money or property to the State.

“Health care claims fraud” according to the NJHCCF means “making, or causing to be made, a false, fictitious, fraudulent, or misleading statement of material fact in, or omitting a material fact from, or causing a material fact to be omitted from, any record, bill, claim or other document, in writing, electronically or in any other form, that a person attempts to submit for payment or reimbursement for health care services.” Violations of the NJHCCF by a practitioner occur when he/she knowingly or recklessly commits health care claims fraud in the course of providing professional services. A person who is not a practitioner violates the NJHCCF when he/she knowingly or recklessly commits health care claims fraud, or knowingly commits five or more acts of health care claims fraud and the aggregate pecuniary benefit is at least one thousand dollars (\$1,000).

***What are the Qui Tam Provisions and Whistleblower Protections?***

The NJFCA contains provisions that allow individuals (or *qui tam* plaintiffs) with original information concerning fraud to file a lawsuit on behalf of the State. Individuals who report fraud receive between 15% and 25% of the total amount recovered if the government prosecutes the case. Individuals who litigate a case on their own without the government can receive a higher recovery of between 25% and 30% of the proceeds. A court may award such sums as it considers appropriate if the court finds that the action was based primarily on disclosures of specific information not provided by the *qui tam* plaintiff.

The NJFCA protects employees who report fraud and consequently suffer discrimination by their employer. An individual may be awarded: (1) reinstatement with the same seniority status; (2) two times the amount of back pay; (3) compensation for any special damages; and (4) if appropriate, punitive damages may be imposed. Employers are also responsible for litigation costs and reasonable attorney fees for the employee.

***What are the Penalties?***

In addition to any other civil, administrative, or criminal remedies that may be prescribed by law, a person who violates the NJFCA fraud provisions is liable for a civil penalty of not less than and not more than the civil penalty allowed under the federal False Claims Act (31 U.S.C. § 3729 *et seq.*) for each false or fraudulent claim plus three times the amount of damages that the State sustains. The current penalties under the federal False Claims Act are \$5,500 to \$11,000 per claim. These penalty amounts may be adjusted for inflation pursuant to the Federal Civil Penalties Inflation Adjustment Act of 1990. A practitioner who violates the NJHCCN is guilty of a crime of the second or third degree, and may be subject to a fine of up to five times the pecuniary benefit obtained or sought to be obtained. A non-practitioner who violates the NJHCCN is guilty of a third or fourth degree crime and may be subject to a fine of up to five times the pecuniary benefit obtained or sought to be obtained, in addition to other criminal penalties allowed by New Jersey law.

Further, the New Jersey Medical Assistance and Health Services Act (N.J.S.A. 30:4D-17) provides for additional penalties that may apply. For example, any person, firm, corporation, partnership, or other legal entity who violates the NJFCA, shall, in addition to any other penalties provided by law, be liable to civil penalties of (1) payment of interest on the amount of the excess benefits or payments at the maximum legal rate in effect on the date the payment was made; (2) payment of an amount not to exceed three-fold the amount of such excess benefits or payments; and (3) payment in the sum of not less than and not more than the civil penalty allowed under the federal False Claims Act, as it may be adjusted for inflation, for each claim for assistance, benefits or payment.

**NEW MEXICO**

***What is the New Mexico Medicaid False Claims Act, Fraud Against Taxpayers Act and Medicaid Fraud Act?***

New Mexico has several applicable statutes to fight false claims. First, is the Medicaid False Claims Act (“MFCA”) (N.M. Stat. §§27-14-1 to 27-14-15) to deter individuals from causing the

state to pay false Medicaid claims and provide remedies for obtaining treble damages. The MFCA became effective on May 19, 2004. Next, is the Fraud Against Taxpayers Act (“FATA”) (N.M. Stat. Ann. §§ 44-9-1 to 44-9-14) is a civil statute that helps the State combat fraud and recover losses resulting from fraud in the New Mexico Medicaid program. The FATA became effective on July 1, 2007. The statutes are very similar, but the main difference is that the FATA is not exclusive to the Medicaid program like the MFCA. Finally, New Mexico maintains a general Medicaid Fraud Act (“MFA”) (N.M.S.A. §30-44-7) that may apply in scenarios involving false claims.\* The MFA became effective on April 8, 1997.

Violations of the MFCA include: (1) presenting to the state a claim for payment under the Medicaid program knowing that such claim is false or fraudulent; (2) presenting, to the state a claim for payment under the Medicaid program knowing that the person receiving a Medicaid benefit or payment is not authorized or is not eligible for a benefit under the Medicaid program; (3) making or using a record or statement to obtain a false or fraudulent claim under the Medicaid program paid for or approved by the state knowing such record or statement is false; (4) conspiring to defraud the state by getting a claim allowed or paid under the Medicaid program knowing that such claim is false or fraudulent; (5) making or using a record or statement to conceal, avoid or decrease an obligation to pay or transmit money or property to the state, relative to the Medicaid program, knowing that such record or statement is false; (6) knowingly applying for and receiving a benefit or payment on behalf of another person and converting the benefit to his own personal use; (7) knowingly making a false statement or misrepresentation of material fact concerning the conditions or operation of a health care facility in order that the facility may qualify for certification or recertification required by the Medicaid program; and (8) knowingly making a claim under the Medicaid program for a service or product that was not provided.

Violations of the FATA<sup>11</sup> include: (1) knowingly presenting or causing to be presented a false or fraudulent claim for payment or approval; (2) knowingly making or causing to be made or used a false, misleading, or fraudulent record or statement to obtain payment of a false or fraudulent claim; (3) conspiring to defraud the State by obtaining approval or payment on a false or fraudulent claim; (4) conspiring to make, use, or cause to be made or used a false, misleading or fraudulent record or statement to conceal, avoid, or decrease a payment obligation to the State; (5) providing less property or money to the State than the amount indicated on a certificate or receipt; (6) knowingly making or delivering a receipt for property that falsely represents a material characteristic of the property; (7) knowingly buying or receiving as a pledge of an obligation or debt, public property that a person may not lawfully sell or pledge; (8) knowingly making or using or causing to be made or used a false, misleading or fraudulent record or statement to conceal, avoid, or decrease an obligation to pay money or property to the State; or (9) as a beneficiary of an inadvertent submission of a false claim and having discovered the falsity of the claim, failing to disclose the false claim to the State within a reasonable time after discovery.

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<sup>11</sup> Proposed legislation would amend the FATA to clarify certain provisions and allow the State to recover attorney fees.

Violations of the MFA include: (1) providing with intent that a claim be relied upon for the expenditure of public money: (a) treatment, services or goods that have not been ordered by a treating physician; (b) treatment that is substantially inadequate when compared to generally recognized standards within the discipline or industry; or (c) merchandise that has been adulterated, debased or mislabeled or is outdated; (2) presenting or causing to be presented for allowance or payment with intent that a claim be relied upon for the expenditure of public money any false, fraudulent, excessive, multiple or incomplete claim for furnishing treatment, services or goods; or (3) executing or conspiring to execute a plan or action to: (a) defraud a state or federally funded or managed health care plan in connection with the delivery of or payment for health care benefits, including engaging in any intentionally deceptive marketing practice in connection with proposing, offering, selling, soliciting or providing any health care service in a state or federally funded or mandated managed health care plan; or (b) obtain by means of false or fraudulent representation or promise anything of value in connection with the delivery of or payment for health care benefits that are in whole or in part paid for or reimbursed or subsidized by a state or federally funded or mandated managed health care plan. This includes representations or statements of financial information, enrollment claims, demographic statistics, encounter data, health services available or rendered and the qualifications of persons rendering health care or ancillary services.

#### ***What are the Qui Tam Provisions and Whistleblower Protections?***

Both the MFCA and FATA contain provisions that allow individuals (or *qui tam* plaintiffs) with original information concerning fraud to file a lawsuit on behalf of the State. Individuals who report fraud receive between 15% and 25% of the total amount recovered if the government prosecutes the case. Individuals who litigate a case on their own without the government can receive a higher recovery of between 25% and 35% of the proceeds. An individual is entitled to not more than 10% if the court finds that the action was based primarily on disclosures of specific information not provided by the *qui tam* plaintiff.

Similarly, both the MFCA and FATA protect employees who report fraud and consequently suffer discrimination by their employer. An individual may be awarded: (1) reinstatement with the same seniority status; (2) two times the amount of back pay with interest; (3) compensation for any special damages; and (4) if appropriate, punitive damages may be imposed. Employers are also responsible for litigation costs and reasonable attorney fees for the employee.

#### ***What are the Penalties?***

New Mexico law provides multiple opportunities for penalties if a violation of one or more of the above-referenced statutes is found, with some limitations. For example, the application of a civil remedy pursuant to the MFCA does not preclude the application of other laws, statutes or regulatory remedy, except that a person may not be liable for a civil remedy pursuant to the MFCA and civil damages or recovery pursuant to the MFA if the civil remedy and the civil damages or recoveries are assessed for the same conduct by another government agency.

Similarly, the remedies provided for in the FATA are not exclusive and shall be in addition to any other remedies provided for in any other law or available under common law. A FATA violation provides for financial penalties of \$5,000 to \$10,000 for each violation plus three times the amount of damages to the State may be imposed, as well as the costs of a civil action to

recover penalties or damages and reasonable attorney fees. The courts reduce damages for violations if the false claims are voluntarily disclosed. Such civil actions must be brought within four years.

Finally, the remedies under the MFA are separate from and cumulative to any other administrative and civil remedies available under federal or New Mexico law or regulation. Whoever commits Medicaid fraud in violation of the MFA may be subject to both civil and criminal penalties and sentencing procedures. For example, if any person who receives payment for furnishing treatment, services or goods under Medicaid, which payment the person is not entitled to receive by reason of a violation of the MFA, shall, in addition to any other penalties or amounts provided by law, be liable for: (1) payment of interest on the amount of the excess payments at the maximum legal rate in effect on the date the payment was made, for the period from the date payment was made to the date of repayment to the state; (2) a civil penalty in an amount of up to three times the amount of excess payments; (3) payment of a civil penalty of up to ten thousand dollars (\$10,000) for each false or fraudulent claim submitted or representation made for providing treatment, services or goods; and (4) payment of legal fees and costs of investigation and enforcement of civil remedies. No action under this section shall be brought after the expiration of five years from the date the action accrues.

In addition, someone who violates the MFA subsection (2) is guilty of a fourth degree felony. Someone who commits Medicaid fraud in violation of MFA subsection (1) or (3) when the value of the benefit, treatment, services or goods improperly provided is: (1) not more than one hundred dollars (\$100), he or she is guilty of a petty misdemeanor; (2) between one hundred dollars (\$100) and two hundred fifty dollars (\$250), he or she is guilty of a misdemeanor; (3) between two hundred fifty dollars (\$250) and two thousand five hundred dollars (\$2,500), he or she is guilty of a fourth degree felony; (4) between two thousand five hundred dollars (\$2,500) and twenty thousand dollars (\$20,000), he or she is guilty of a third degree felony; and (5) more than twenty thousand dollars (\$20,000), he or she is guilty of a second degree felony. Further, the MFA states that if the person who commits the Medicaid fraud is an entity rather than an individual, the entity shall be subject to a fine of not more than fifty thousand dollars (\$50,000) for each misdemeanor and not more than two hundred fifty thousand dollars (\$250,000) for each felony.

\*Proposed legislation regarding the General Medicare Fraud Act (Section 30-44-7), would provide a standard of review for Medicaid fraud utilizing an external Medicaid program auditor that is certified by the department.

## **NORTH DAKOTA**

### ***What are the North Dakota Medicaid Provider Integrity Laws?***

North Dakota is one of two remaining states in the United States that has not established a Medicaid Fraud Control Unit overseen by the government. Although North Dakota does not have an official state false claims act, North Dakota's Medicaid provider integrity laws and regulations impose liability on those who submit false claims for the purpose of obtaining government funds. (*See generally* Medicaid Provider Integrity, N.D. Cent. Code § 50-24.1-01.3; N.D. Admin. Code §§ 75-02-05-01 to 75-02-05-08; 72-02-06-02(4); Remedies N.D. Cent.

Code §§ 32-03-01 to 32-03-56; and Whistleblower Protections, N.D. Cent. Code §§ 34-01-20; N.D. Cent. Code § 50.10.1-05; and N.D. Admin. Code § 75-03-25-13, prohibiting retaliatory action for providing information to the long-term care ombudsman).

These North Dakota laws can apply to Medicaid reimbursement and prohibit the following: (1) presenting a false or fraudulent claim; (2) submitting false information to obtain greater compensation than what is entitled; (3) submitting false information for the purpose of meeting prior authorization requirements; (4) submitting a false or fraudulent application to obtain provider status; (5) submitting false Medicaid cost reports; (6) failing to disclose records of services provided to Medicaid recipients; (7) failing to comply with the terms of the Medicaid provider agreement; (8) over utilizing the Medicaid program by inducing or providing unnecessary services; and (9) participating in kickbacks or rebates.

### ***What are the Qui Tam Provisions and Whistleblower Protections?***

North Dakota law only allows civil lawsuits to recover monetary filed by the government, not individuals (or *qui tam* plaintiffs). There is no provision for a private citizen to share a percentage of any monetary recoveries.

North Dakota also has laws that prohibit both private and public employers from retaliating or discriminating against employees for their good faith disclosure of information pertaining to a violation of a law, or their participation in an investigation. Employees may bring a civil lawsuit for injunctive relief or actual damages (or both) if he suffers retaliatory action. The court may award reinstatement, back-pay, injunctive relief, reinstatement of fringe benefits or a combination of remedies.

### ***What are the Penalties?***

Violations can result in sanctions by the North Dakota Department of Human Services, including recovery of overpayments, termination from participation in the Medicaid program, and prosecution under applicable state or federal laws.

\*According to the North Dakota Sixty-Third Legislative Assembly's Senate Concurrent Resolution No. 4007, North Dakota has adopted a concurrent resolution to study the growth and use of state False Claims Acts with *qui tam* provisions in other states and to determine whether that approach is "feasible and desirable" in North Dakota.

## **OHIO**

### ***What are the Ohio Laws?***

While Ohio does not have a false claims statute closely paralleling the federal False Claims Act, Ohio has a collection of laws that serve the same purpose to prevent the commission of fraud (Ohio Rev. Code Ann. §§§§§ 2913.40; 2913.401; 2921.13; 4113.52; 2307.65).

The chief actions that violate this law are (1) knowingly making or causing to be made a false or misleading statement or representation for use in obtaining reimbursement from the medical assistance program, (2) purposefully and knowingly charging, soliciting, accepting or receiving any property, money or other consideration in addition to the amount of reimbursement under the

medical assistance program to which the person would otherwise be entitled, (3) purposefully and knowingly soliciting, offering or receiving any remuneration, other than authorized deductibles or co-payments, in cash or in kind, including, but not limited to, a kickback or rebate, in connection with the furnishing of goods or services for which whole or partial reimbursement is or may be made under the medical assistance program, and (4) knowingly altering, falsifying, destroying, concealing, or removing any records within six years after submitting a claim under the medical assistance program that are necessary to fully disclose the nature of all goods and services on which the claim was submitted or for which reimbursement was received or that are necessary to disclose fully all income and expenditures upon which rates or reimbursement were based.

Ohio law prohibits false statements made in connection with an application for Medicaid eligibility. (Ohio Rev. Code Ann. § 2913.401). In particular, no person shall knowingly (1) make false or misleading statements in a Medicaid benefits or disclosure application or document, (2) conceal an interest in property in a Medicaid benefits or disclosure application or document, or (3) fail to disclose a transfer of property that occurred during the period thirty-six months before submission of the application or document.

Ohio law also prohibits the making of false statements in many situations, including (1) in any official proceeding, (2) with the purpose of securing government benefits, (3) with the purpose to mislead a public official in performing the public official's official function, and (4) with the purpose of obtaining an Ohio's "best Rx program" enrollment card. (Ohio Rev. Code Ann. § 2921.13).

#### ***What are the Qui Tam Provisions and Whistleblower Protections?***

The Ohio laws described above *do not* contain provisions that allow individuals (or *qui tam* plaintiffs) with original information concerning fraud to file a lawsuit on behalf of the state.

However, private employees are afforded whistleblower protections (Ohio Rev. Code Ann. § 4113.51 to 4113.53). For example, employers are prohibited from taking any "disciplinary or retaliatory action against an employee for making any report...disciplinary or retaliatory action by the employer includes, without limitation, doing any of the following: (1) Removing or suspending the employee from employment; (2) Withholding from the employee salary increases or employee benefits to which the employee is otherwise entitled; (3) Transferring or reassigning the employee; (4) Denying the employee a promotion that otherwise would have been received; or (5) Reducing the employee in pay or position. (Ohio Rev. Code Ann. § 4113.53).

#### ***What are the penalties?***

(A) The attorney general may bring a civil action in the Franklin county court of common pleas on behalf of the department of Medicaid, and the prosecuting attorney of the county in which a violation of division (B) of section 2913.401 of the Revised Code occurs may bring a civil action in the court of common pleas of that county on behalf of the county department of job and family services, against a person who violates division (B) of section 2913.401 of the Revised Code for the recovery of the amount of benefits paid on behalf of a person that either department would not have paid but for the violation minus any amounts paid in restitution under division (C)(2) of section 2913.401 of the Revised Code and for reasonable attorney's fees and all other fees and costs of litigation (Ohio Rev. Code Ann. § 2307.65)

Violations of Section 2913.40 (related to Medicaid fraud), Section 2913.401 (related to Medicaid eligibility fraud), and Section 2921.13 (related to certain false statements) result in penalties ranging from a first degree misdemeanor to a third, fourth or fifth degree felony, depending on the value of the property, services or funds obtained.

A person found guilty of violating Section 2913.40 may have to pay the costs of the investigation and prosecution of the violation. A person found guilty of Section 2913.401 can be compelled to make restitution of the amount of benefits received for which the applicant or recipient was not eligible (plus interest). A person who violates Section 2921.13 is liable in a civil action to any person harmed by the violation. The remedies set forth in Sections 2913.40, 2913.401, and 2921.13 do not preclude the use of any other criminal or civil remedy.

## **OREGON**

### ***What is the Oregon False Claims Act & the False Claims for Health Care Payments Act?***

The Oregon False Claims Act (“OFCA”) is a civil statute designed to help the state government combat fraud and recover losses resulting from fraud against public agencies. (Or. Rev. Stat. Ann. § § 180.765 to 180.785). The OFCA became effective on January 10, 2010. Also, Oregon has a False Claims for Health Care Payments Act (“OFCHCP”) (O.R.S. §§165.690 to 165.698) which works to fight false claims for health care payments. The OFCHCP became effective in 1995.

Violations of the OFCA include: (1) presenting or causing to be presented for payment or approval a claim that the person knows is false; (2) in the course of presenting a claim for payment or approval, making or using a false record or statement that the person knows to contain, or to be based on, false or fraudulent information; (3) agreeing or conspiring with other persons to present for payment or approval a claim that the person knows is a false claim; (4) delivering, or causing to be delivered, property to a public agency in an amount the person knows is less than the amount for which the person receives a certificate or receipt; (5) making or delivering a document certifying receipt of property used by a public agency, or intended to be used by a public agency, that the person knows contains false or fraudulent information; (6) buying property of a public agency from an officer or employee of a public agency if the person knows that the officer or employee is not authorized to sell the property; (7) receiving property of a public agency from an officer or employee of the public agency as a pledge of an obligation or debt if the person knows that the officer or employee is not authorized to pledge the property; (8) making or using, or causing to be made or used, a false or fraudulent statement to conceal, avoid or decrease an obligation to pay or transmit moneys or property to a public agency if the person knows that the statement is false or fraudulent; or (9) failing to disclose a false claim that benefits the person within a reasonable time after discovering that the false claim has been presented or submitted for payment or approval.

Violations of the OFCHCP occur when a person, defined as an individual, corporation, partnership or association providing health care services or any other form of legal or business entity providing health care services, does the following: (1) knowingly makes or causes to be made a claim for health care payment that contains any false statement or false representation of a material fact in order to receive a health care payment; or (2) knowingly conceals from or fails

to disclose to a health care payor the occurrence of any event or the existence of any information with the intent to obtain a health care payment to which the person is not entitled, or to obtain or retain a health care payment in an amount greater than that to which the person is or was entitled.

### ***What are the Qui Tam Provisions and Whistleblower Protections?***

The OFCA *does not* contain provisions that allow individuals (or *qui tam* plaintiffs) with original information concerning fraud to file a lawsuit on behalf of the state. Actions may be brought by the Oregon Attorney General on behalf of the state. All damages assessed for violations of the OFCA are awarded to the state. Similarly, violations of the OFCHCP may be prosecuted only by the district attorney or the Attorney General.

### ***What are the Penalties?***

A claim for violating the OFCA must be brought within three years after the date that the officer or employee of the public agency charged with responsibility for the claim discovers the violation. Courts are instructed to award to the state all damages arising from a violation of the OFCA, as well as a penalty equal to the greater of \$10,000 for each violation or an amount equal to twice the amount of damages incurred for each violation. Courts may also award attorney's fees and costs of investigation, preparation and litigation to the state if the state prevails. Damages are calculated using the market value of the property, services or benefits obtained by the person who made the claim at the time and place of receipt or delivery. If the market value cannot be established, damages may be calculated using the replacement value or through another measure that reasonably estimate damages incurred.

The penalty portion of the award may be mitigated if the defendant is also subject to fines or penalties for substantially the same acts and omissions under the Federal False Claims Act or the Federal Civil Monetary Penalties Law. In addition, the penalty may not be imposed if the defendant (1) provided the Attorney General with all the information known to the defendant about the violation within 30 days of acquiring the information, (2) fully cooperated with the Attorney General in the investigation, and (3) at the time the defendant provided the Attorney General with information about the violation, a court proceeding or administrative action related to the violation had not commenced. If a court finds that an act or omission of an individual on behalf of a corporation constituted a violation of OFCA, the court may impose a separate penalty against both the individual and the legal entity.

Although the OFCHCP does not have its own set of penalties, the statute requires that the prosecuting attorney must notify the Oregon Health Authority and any appropriate licensing boards of a person convicted under the OFCHCP.

## **PENNSYLVANIA**

### ***What is Pennsylvania's Fraud and Abuse Control Act?***

Pennsylvania maintains a Fraud and Abuse Control Act ("PFAC") (62 P.S. § 1403 *et seq.*) aimed at protecting the state Medicaid program from incidents of provider fraud and abuse through the use of civil and criminal penalties. Generally, the PFAC prohibits false claims, kickbacks, services not provided, and various types of provider claims.

Among other enumerated activities, the PFAC prohibits any person from: (1) knowingly or intentionally presenting for allowance or payment any false or fraudulent claim or cost report for furnishing services or merchandise under the Medicaid program; (2) knowingly presenting for allowance or payment any claim or cost report for medically unnecessary services or merchandise under the Medicaid program; (3) knowingly submitting false information, for the purpose of obtaining greater compensation than that to which he or she is legally entitled for furnishing services or merchandise under the Medicaid program; or (4) knowingly submitting false information for the purpose of obtaining or furnishing services or merchandise under the Medicaid program. Additionally, the PFAC disallows: (1) submitting a duplicate claim for services, supplies, or equipment for which the provider has already received or claimed reimbursement from any source; (2) submitting a claim for services, supplies or equipment which were not rendered to a patient; (3) submitting a claim for services, supplies or equipment which includes costs or charges not related to said services, supplies or equipment rendered to the patient; (4) submitting a claim for services, supplies, or equipment which are not documented in the record in the prescribed manner and are of little or no benefit to the recipient, are below the accepted medical treatment standards, or are unneeded by the patient; (5) submitting a claim which misrepresents the description of services, supplies or equipment dispensed or provided; the dates of services; the identity of the recipient; the identity of the attending, prescribing or referring practitioner; or the identity of the actual provider; (6) submitting a claim for reimbursement for a service, charge or item at a fee or charge which is higher than the provider's usual and customary charge to the general public for the same service or item; or (7) submitting a claim for a service or item which was not rendered by the provider.

#### ***What are the Qui Tam Provisions and Whistleblower Protections?\****

Separate from the PFAC, Pennsylvania has a Pennsylvania Whistleblower Law (“PWL”) (43 P.S. §§ 1421 to 1428), which provides protection from discrimination and retaliation to any person who witnesses or has evidence of wrongdoing or waste while employed by a public body and who makes a good faith report of the wrongdoing or waste to one of the person’s superiors, to an agent of the employer or to an appropriate authority. The PWL further provides that no employer may discharge, threaten or otherwise discriminate or retaliate against an employee after he makes such a good faith report.

\*Effective September 2, 2014, definitions in the PWL are amended to further protect employees and their penalties. Relevant changes include Section 1422, which further defines “employer” under the statute. Section 1423 has been amended to add a section (3) which prohibits disclosure by the appropriate authority to the identity of a whistleblower without the whistleblower’s consent, unless disclosure is unavoidable.

In addition, effective September 2, 2014, the maximum civil fines have increased for violations of PWL. These fines have increased from up to \$500 to a maximum fine of \$10,000.

#### ***What are the Penalties?***

Any person who violates the PFAC is guilty of a felony of the third degree for each such violation with a maximum penalty of fifteen thousand dollars (\$15,000) and seven years imprisonment. Whenever any person has been previously convicted in any state or Federal court of conduct that would constitute a violation of the PFAC, a subsequent allegation, indictment or

information under the PFAC shall be classified as a felony of the second degree with a maximum penalty of twenty-five thousand dollars (\$25,000) and ten years imprisonment. In addition, the trial court shall order any person convicted under the PFAC to: (i) repay the amount of the excess benefits or payments plus interest on that amount at the maximum legal rate from the date payment was made by the Commonwealth to the date repayment is made to the Commonwealth and (ii) pay an amount not to exceed threefold the amount of excess benefits or payments. Further, any person convicted under the PFAC shall be ineligible to participate in Medicaid for a period of five years from the date of conviction.

If a violation occurs, the state has the authority to immediately terminate, upon notice to the provider, the provider agreement and to institute a civil suit against such provider for twice the amount of excess benefits or payments plus legal interest from the date the violation occurred. Providers who are terminated from participation in Medicaid are prohibited from owning, arranging for, rendering or ordering any service for Medicaid recipients during the period of termination. In addition, such provider may not receive, during the period of termination, reimbursement in the form of direct payments from the state or indirect payments of Medicaid funds in the form of salary, shared fees, contracts, kickbacks or rebates from or through any participating provider.

Furthermore, if retaliatory actions arising out of a PFAC violation in turn violate the PWL, it can yield additional civil penalties.

## **SOUTH DAKOTA**

### ***What are South Dakota's False Claims Laws?***

Currently there is no state false claims act in South Dakota. However, the state does have a law entitled "Unlawfully Obtaining Benefits or Payments from Medical Assistance Program" (S.D. Codified Laws §§ 22-45-1 to 22-45-11). This law imposes liability on persons or organizations that make or cause to be made false Medicaid claims to the government for payment, or who make or cause to be made a false record or statement to get a claim or invoice paid by the government.

This South Dakota laws can apply to Medicaid reimbursement and prohibit (1) making a false claim to the state for payment; (2) making any false representation in order to obtain authorization to provide a good or service; (3) making any false representation for use by another in order to obtain a Medicaid good or service; (4) making a false statement to qualify as a Medicaid provider; (5) submitting any Medicaid enrollment application, cost report or invoice for payment that contains a false material statement; (6) participating in kickbacks or rebates; and (7) intentionally failing to retain the necessary records upon which a Medicaid claim or payment rate is based.

### ***What are the Qui Tam Provisions and Whistleblower Protections?***

Currently, unlike the federal law, South Dakota law only allows lawsuits to be filed by the state government and not private individuals (or qui tam plaintiffs). There is no provision for a private individual to share a percentage of any monetary recoveries.

Whistleblower protections used to exist in South Dakota but have since been repealed by the legislature.

***What are the Penalties?***

A violation of the South Dakota law must be brought within six years from the cause of action accruing. Penalties in South Dakota include payment of interest on the amount of the excess payment, a civil penalty of \$2,000 for each false claim or statement, and/or up to three times the amount of damages, including the cost of investigation and litigation.

In addition, violations of these laws are punishable as a Class 5 felony. The intentional failure to retain the necessary records upon which a Medicaid claim or payment rate is based is a Class 1 misdemeanor. Violations of any of these laws may also result in termination from participation in the Medicaid program.

**TENNESSEE**

***What are the Tennessee laws?***

Tennessee has multiple false claims acts. The Tennessee Medicaid False Claims Act (“TMFCA”) (Tenn. Code Ann. §§ 71-5-181 to 71-5-185) combats fraud and recovers losses but applies solely to false claims under the Tennessee Medicaid program, and was recently amended to mirror the federal law. The TMFCA became effective on July 1, 1993. The Tennessee False Claims Act (“TFCA”) (Tenn. Code Ann. §§ 4-18-101 to 4-18-103) helps the state combat fraud and recover losses resulting from fraud in programs, purchases, or contracts. It applies to claims that involve funds of the state or any political subdivision. The TFCA became effective on July 1, 2001. Finally, Tennessee maintains a TennCare Fraud and Abuse Reform Act of 2004 (“TFAR”) (T. C. A. § 71-5-2501) which aims at preventing fraud and abuse of the state Medicaid program, called TennCare.

Violations of both the TFCA and TMFCA can include: (1) knowingly submitting a false claim for payment or approval, (2) knowingly making or using a false record or statement to get a false claim paid or approved, (3) conspiring to defraud the state by getting a false claim allowed or paid, or (4) knowingly making or using a false record to conceal or avoid payments owed. In addition, anyone who benefits from a false claim that was mistakenly submitted violates the TFCA if he or she does not disclose the false claim soon after he or she discovers it. The TFCA also broadly prohibits using any false representation or practice to procure anything of value from the state government or any political subdivision.

A violation of the TFAR occurs when a person, firm, corporation, partnership or any other entity: (1) knowingly obtains, or attempts to obtain, or aids or abets any person or entity to obtain, by means of a willfully false statement, report, representation, claim or impersonation, or by concealment of any material fact, or by any other fraudulent means, including knowingly presenting or causing to be presented to TennCare or any of its contractors, subcontractors or vendors a false or fraudulent claim for payment or approval, or in any manner not authorized by any rule, regulation, procedure, or statute governing TennCare, medical assistance payments provided pursuant to any rule, regulation, procedure, or statute governing TennCare to which the person or entity is not entitled, or of a greater value than that to which the person or entity is

authorized; or (2) provides a willfully false statement regarding another's medical condition or eligibility for insurance, to aid or abet another in obtaining or attempting to obtain medical assistance payments, medical assistance benefits or any assistance provided under any rule, regulation, procedure, or statute governing TennCare to which the person is not entitled or to a greater value than that to which such person is authorized.

### ***What are the Qui Tam Provisions and Whistleblower Protections?***

The TFCA and TMFCA contain provisions that allow individuals (or *qui tam* plaintiffs) with “original” information concerning fraud to file a lawsuit on behalf of the state. This means that a *qui tam* plaintiff must (1) have direct and independent knowledge of the information on which the allegations are based, (2) voluntarily provide this information to the state or political subdivision before filing an action based on that information, and (3) have provided the basis or catalyst for the investigation, hearing, audit, or report that led to the public disclosure of allegations. (22 Tenn. Prac. Contract Law and Practice § 13:72 (2012)).

Individuals who report fraud receive between 25% and 33% of the total amount recovered if the government prosecutes the case under the TFCA and between 15% and 25% under the TMFCA. Individuals who litigate a case on his or her own without the government can receive a higher recovery.

Both the TFCA and TMFCA<sup>12</sup> contain important protections against retaliation for whistleblowers. Employees who report fraud and consequently suffer discrimination by their employer may be awarded: (1) two times their back pay plus interest, (2) reinstatement at the seniority level they would have had except for the discrimination, and (3) compensation for any costs or damages they have incurred. Under the TFCA, the employer may also be liable for punitive damages.

### ***What are the Penalties?***

Financial penalties of \$2,500 to \$10,000 per claim plus two to three times the amount of damages to the state or political subdivision may be imposed for TFCA violations. Penalties of \$5,000 to \$25,000 per claim plus treble damages may be imposed for TMFCA violations. The courts can waive penalties and reduce damages for violations if the false claims are voluntarily disclosed.

An individual who violates subsection the TFAR is guilty of either (i) a Class B felony when the value of the services unlawfully obtained is between sixty thousand dollars (\$60,000) and two hundred fifty thousand dollars (\$250,000); (ii) a Class C felony if the value of the services unlawfully obtained is between ten thousand dollars (\$10,000) and sixty thousand dollars (\$60,000); or (iii) a Class D felony when the value of services unlawfully obtained is between one thousand dollars (\$1,000) and ten thousand dollars (\$10,000). Additionally, in addition to any other penalty, a sentence that includes a fine, when imposed upon an entity or upon a person for actions benefiting an entity shall include a corporate fine, determined by a jury, as follows: (a) for a Class B felony, between eight (8) and fifteen (15) years imprisonment and a fine not to

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<sup>12</sup> Proposed legislation would provide additional protection against crimes of retaliation.

exceed fifty thousand dollars (\$50,000); (b) for a Class C felony, between three (3) and fifteen (15) years imprisonment and a fine not to exceed ten thousand dollars (\$10,000); (c) for a Class D felony, between two (2) and twelve (12) years imprisonment and a fine not to exceed five thousand dollars (\$5,000).

In addition to any other penalties provided for any person, firm, corporation, partnership or other entity under the TFAR, the court may also: (i) order restitution to TennCare; (ii) report the person or entity to the appropriate professional licensure board or the department of commerce and insurance for disciplinary action; (iii) order any such person or entity disqualified from participation in the medical assistance program; and (iv) the state may recover from any person or such person's estate, or from a firm, corporation, partnership or other entity, the amount of medical assistance benefits or payments improperly paid as a result of fraudulent means or actions not authorized by any rule, regulation, procedure, or statute governing TennCare. Prosecutions for violations of the TFAR must be commenced within four (4) years after the commission of the offense.

## **TEXAS**

### ***What is the Texas Medicaid Fraud Prevention Act?***

The Texas Medicaid Fraud Prevention Act (“TMFPA”) (Tex. Hum. Res. Code §§ 36.001-132) establishes a cause of action for false claims for payment from the Medicaid program. The TMFPA provides that the Attorney General or a private citizen may prosecute cases under the TMFPA, and grants the Attorney General the authority to issue civil investigation demands to investigate potential Medicaid fraud. The TMFPA became effective on September 1, 1995.

Violations of the TMFPA include: (1) knowingly making or causing to be made a false statement or misrepresentation of a material fact to permit a person to receive a benefit or payment under the Medicaid program that is not authorized or that is greater than the benefit or payment that is authorized; (2) knowingly concealing or failing to disclose information that permits a person to receive a benefit or payment under the Medicaid program that is not authorized or that is greater than the benefit or payment that is authorized; (3) knowingly applying for and receiving a benefit or payment on behalf of another person under the Medicaid program and converting any part of the benefit or payment to a use other than for the benefit of the person on whose behalf it was received; (4) knowingly making, causing to be made, inducing, or seeking to induce the making of a false statement or misrepresentation of material fact concerning: (i) the conditions or operation of a facility in order that the facility may qualify for certification or recertification required by the Medicaid program, including certification or recertification as a hospital; a nursing facility or skilled nursing facility; a hospice; an intermediate care facility for the mentally retarded; an assisted living facility; or a home health agency; or (ii) information required to be provided by a federal or state law, rule, regulation, or provider agreement pertaining to the Medicaid program; (5) except as authorized under the Medicaid program, knowingly paying, charging, soliciting, accepting, or receiving, in addition to an amount paid under the Medicaid program, a gift, money, a donation, or other consideration as a condition to the provision of a service or product or the continued provision of

a service or product if the cost of the service or product is paid for, in whole or in part, under the Medicaid program; (6) knowingly presenting or causing to be presented a claim for payment under the Medicaid program for a product provided or a service rendered by a person who (i) is not licensed to provide the product or render the service, if a license is required; or (ii) is not licensed in the manner claimed; (7) knowingly making or causing to be made a claim under the Medicaid program for (i) a service or product that has not been approved or acquiesced in by a treating physician or health care practitioner; (ii) a service or product that is substantially inadequate or inappropriate when compared to generally recognized standards within the particular discipline or within the health care industry; or (iii) a product that has been adulterated, debased, mislabeled, or that is otherwise inappropriate; (8) making a claim under the Medicaid program and knowingly failing to indicate the type of license and the identification number of the licensed health care provider who actually provided the service; (9) conspiring to commit a violation of the TMFPA; (10) is a managed care organization that contracts with the Health and Human Services Commission or other state agency to provide or arrange to provide health care benefits or services to individuals eligible under the Medicaid program and knowingly (i) fails to provide to an individual a health care benefit or service that the organization is required to provide under the contract; (ii) fails to provide to the commission or appropriate state agency information required to be provided by law, commission or agency rule, or contractual provision; or (iii) engages in a fraudulent activity in connection with the enrollment of an individual eligible under the Medicaid program in the organization's managed care plan or in connection with marketing the organization's services to an individual eligible under the Medicaid program; (11) knowingly obstructing an investigation by the Attorney General of an alleged unlawful act under this section; (12) knowingly making, using, or causing the making or use of a false record or statement material to an obligation to pay or transmit money or property to this state under the Medicaid program, or knowingly concealing or knowingly and improperly avoiding or decreasing an obligation to pay or transmit money or property to this state under the Medicaid program; or (13) knowingly engaging in conduct that constitutes a violation of the Texas Medical Assistance Program.

### ***What are the Qui Tam Provisions and Whistleblower Protections?***

Under the TMFPA, a private person may bring a civil action for a violation of the TMFPA for the person and for the state. The action shall be brought in the name of the person and of the state. Unlike the Federal FCA, *qui tam* complaints remain sealed for 180 days, as opposed to 60 days. The TMFPA also has no statute of limitations unlike the Federal FCA.

Texas provides for robust whistleblower protections and a person, including an employee, contractor, or agent, who is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment because of a lawful act taken by the person or associated others in furtherance of an action under the TMFPA, including investigation for, initiation of, testimony for, or assistance in an action filed or to be filed, or other efforts taken by the person to stop one or more violations of Texas Medical

Assistance Program is entitled to: (1) reinstatement with the same seniority status the person would have had but for the discrimination; and (2) not less than two times the amount of back pay, interest on the back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorney's fees. However, a person must bring suit on an action under this section not later than the third anniversary of the date on which the cause of action accrues (the date the retaliation occurs).

### ***What are the Penalties?***

Violators of the TMFPA are subject to civil penalties ranging \$5,500 to \$11,000 for each violation. The TMFPA also provides for penalties ranging from \$5,500 to \$15,000 for unlawful acts that result in injuries to elderly, disabled, or persons under the age of 18.

Violators may also be held liable for the amount of any payment or the value of any monetary or in-kind benefit provided under the Medicaid program, directly or indirectly, as a result of the unlawful act, including any payment made to a third party; interest on the amount of the payment or the value of the benefit at the prejudgment interest rate in effect on the day the payment or benefit was received or paid, for the period from the date the benefit was received or paid to the date that the state recovers the amount of the payment or value of the benefit; and two times the amount of the payment or the value of the benefit.

## **WASHINGTON**

### ***What are the Washington Health Care False Claims Act & Medicaid Fraud False Claims Act?***

Washington has two false claims acts. The Washington Health Care False Claim Act (“WHCFCA”) is a state law directed at eliminating the costs of fraudulent health care claims by establishing specific penalties and deterrents through Washington’s Insurance Code. (Rev. Code Wash. §§ 48.80.010 to 48.80.900). The Washington Medicaid Fraud False Claims Act (“WMFFCA”) (Wash. Rev. Code Ann. § 74.66.005 *et seq.*) provides similar penalties and deterrents aimed specifically at false Medicaid claims.

Violations of the WHCFCA include: (1) making or presenting or causing to be made or presented a knowingly false claim, (2) knowingly presenting a claim that falsely represents that the goods or services were medically necessary, (3) knowingly making a false statement or false representation of a material fact for use in determining rights to a payment, (4) concealing the occurrence of any event affecting rights to have a payment made for a specified health care service, or concealing or failing to disclose any information with intent to obtain a health care payment to which a person is not entitled, or a payment in an amount greater than what a person is entitled, and (5) in the case of a health service provider, willfully collecting or attempting to collect an amount from an insured knowing that it is in violation of an agreement or contract with a health care payor to which the provider is a party.

Similarly, WMFFCA violations occur when a person (a) knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval; (b) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim; (c) conspires to commit a WMFFCA violation; (d) has possession, custody, or control of property or

money used, or to be used, by the government entity and knowingly delivers, or causes to be delivered, less than all of that money or property; (e) is authorized to make or deliver a document certifying receipt of property used, or to be used, by the government entity and, intending to defraud the government entity, makes or delivers the receipt without completely knowing that the information on the receipt is true; (f) knowingly buys, or receives as a pledge of an obligation or debt, public property from an officer or employee of the government entity who lawfully may not sell or pledge property; or (g) knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the government entity, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the government entity.

### ***What are the Qui Tam Provisions and Whistleblower Protections?***

The WHCFCA *does not* contain provisions that allow individuals (or *qui tam* plaintiffs) with original information concerning fraud to file a lawsuit on behalf of the state.

However, the WMFFCA contains a provision allowing *qui tam* plaintiffs to initiate an action.

### ***What are the Penalties?***

Violators of the WHCFCA are guilty of a class C felony. (Rev. Code Wash. § 48.80.030). Additionally, regulatory and disciplinary agencies will be informed of the conviction. Prosecution under the WHCFCA does not preclude action under any other applicable state law. The WHCFCA does not apply to statements made on an application for coverage under a contract or certificate of health care coverage issued by an insurer, health care service contractor, health maintenance organization, or other legal entity which is self-insured and providing health care benefits to its employees.

At a maximum, violators of the WMFFCA face a civil penalty of up to \$5,500 to \$11,000, plus three times the amount of damages which the government entity sustains. The Washington Attorney General will annually adjust civil penalties to match the federal false claims act. Additionally, a violator is responsible for the costs of litigation. (Wash. Rev. Code Ann. § 74.66.020). At a minimum, the court must award no less than two times the amount of damages incurred, even if (1) the violator came forward with relevant information within 30 days of obtaining it; (2) the violator fully cooperated with the investigation; and (3) or the violator had no actual knowledge of the investigation into the violation and at the time, no criminal, civil or administrative action had commenced. (Wash. Rev. Code Ann. § 74.66.020).

## **WISCONSIN**

### ***What is the Wisconsin Medicaid False Claims for Medical Assistance Act?***

Wisconsin's False Claims for Medical Assistance ("FCMA") is a civil statute designed to help the state government combat fraud and recover losses resulting from fraud against its Medical Assistance (Medicaid) program. (Wis. Stat. Ann. § 20.931). This same provision is additionally mentioned under Wisconsin's false medical claims made in connection with public assistance and children and family services (Wis. Stat. Ann. § 49.485). The FCMA became effective on April 19, 2012.

Violations of the FCMA include: (1) presenting or causing to be presented a false claim for medical assistance to an officer, employee, or agent of the state; (2) making or using, or causing to be made or used, a false record or statement material to false claim for medical assistance; (3) making, using, or causing to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay the Medical Assistance program; (4) conspiring to obtain allowance of a false claim for medical assistance or conspiring to make or use a false record or statement to avoid an obligation to pay the Medical Assistance program; and (5) failure of a beneficiary of a false claim for medical assistance to disclose the false claim to the state within a reasonable time after becoming aware that it is false.

### ***What are the Qui Tam Provisions and Whistleblower Protections?***

The FCMA contains provisions that allow individuals (or *qui tam* plaintiffs) to file a lawsuit to enforce the FCMA on behalf of the state. Once filed, the Wisconsin Attorney General may choose to intervene and conduct the lawsuit. If the Attorney General conducts the lawsuit, the *qui tam* plaintiff shall receive between 15% and 25% of the proceeds from the action or settlement of the claim, depending on the extent to which the *qui tam* plaintiff contributed to the prosecution of the lawsuit. If the Attorney General does not conduct the lawsuit, the *qui tam* plaintiff may prosecute the lawsuit and, if successful, will receive between 25% and 30% of the proceeds from the action or settlement, and shall have reasonable and necessary court costs and attorney fees reimbursed by the defendant.

The FCMA protects employees who are discharged, demoted, suspended, harassed, or otherwise discriminated against in terms of their employment, because they take lawful steps to bring a claim for violation of the act. Such employees are entitled to all relief necessary to make them whole, including reinstatement with the seniority status they would have had, two times the amount of back pay, interest on the back pay, and compensation for any special damages sustained as a result of the discrimination.

### ***What are the Penalties?***

The FCMA establishes financial penalties of \$5,000 to \$10,000 for each violation plus three times the amount of damages sustained by the state as a result of the violation. In addition, persons found to have violated the FCMA are liable to the state or to the *qui tam* plaintiff for the costs of the action. If a court finds that the person who committed the violation cooperated with the state investigation of the violation, including furnishing the state with all information known about the violation within 30 days, the court may lower the amount to two times the amount of damages sustained by the state and waive the financial penalty.