

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 CommonSpirit hospitals operate. This list will be updated from time to time as additional states implement such laws.

ARIZONA

What laws in Arizona serve the purpose of preventing the commission of fraud?

Arizona does not have a separate false claims statute closely paralleling the federal False Claims Act, but it does have a collection of laws that serve the same purpose of preventing the commission of fraud. One of Arizona's insurance laws prohibits knowingly presenting, causing to be presenting, or preparing with the knowledge or belief that it will be presented, an oral or written statement, including computer-generated documents, to or by an insurer, reinsurer, purported insurer or reinsurer, insurance producer or agent of a reinsurer that contains untrue statements of material fact or that fails to state any material fact with respect to a claim for payment or benefit pursuant to an insurance policy. Ariz. Rev. Stat. § 20-463(A)(1)(c). This is echoed by Arizona's trade and commerce law prohibiting fraudulent insurance claims, which prohibits presenting a false or fraudulent claim or proof in support of such a claim, upon a contract of insurance for payment of any loss, or preparing, making, or subscribing to an account, certificate of survey, affidavit or proof of loss or other book, paper, or writing, with intent to present or use it or allow it to be presented or used in support of such a claim. Ariz. Rev. Stat. § 44-1220. Additionally, Arizona's Medicaid regulations prohibit presenting or causing to be presented to the state: claims for medical or other items or services that the person knows or has reason to know was not provided as claimed; claims for a medical or other item or service that the person knows or has reason to know is false or fraudulent; claims for payment that the person knows or has reason to know may not be made by the system because the person was terminated or suspended from participation in the program on the date for which the claim is being made, the item or service claimed is substantially in excess of the needs of the individual or of a quality that fails to meet professionally recognized standards of health care, or the patient was not a member on the date for which the claim is being made; a claim for a physician's service or item or service incidental to a physician's service by a person who knows or has reason to know that the individual who furnished or supervised the furnishing of the service was not licensed as a physician, obtained the license through a misrepresentation of material fact, or represented to the patient at the time the service was furnished that the physician was certified in a medical specialty when the individual was not certified; and requests for payment that are in violation of an agreement with the state or Medicaid administrator. Ariz. Rev. Stat. § 36-2918(A). Lastly, Arizona's criminal code prohibits concealing a material fact by any trick, scheme, or device or making or using any false writing or document knowing such writing or document contains any false, fictitious, or fraudulent statement in any matter related to the business conducted by a department or agency of the state. Ariz. Rev. Stat. § 13-2311.

What are the Qui Tam Provisions and Whistleblower Protections?

Arizona's anti-fraud laws do not contain *qui tam* provisions. However, Arizona does have whistleblower protection laws. An employee has a claim against an employer if the employer terminated the employee in retaliation for: (1) the employee's refusal to commit an act or omission that would violate Arizona's laws or constitution, and (2) the employee's disclosure in a reasonable manner that the employee has information or a reasonable belief that the employer or one of its employees has violated, is violating, or will violate the laws or constitution of Arizona to the employer or a representative of the employer who the employee reasonably believes is an employee of the state or in a managerial or supervisory position and has the authority to investigate the information provided by the employee and to take action to prevent further violations of the laws or constitution of Arizona. Ariz. Rev. Stat. Ann. § 23-1501(A)(3)(c)(i)-(ii).

Additionally, health care institutions are required to adopt a policy that prohibits retaliatory action against a health professional who, in good faith: (1) makes a report to the health care institution pursuant to statutory requirements, and (2) having provided the health care institution a reasonable opportunity to address the report, provides information to a private health care accreditation organization or governmental entity concerning the activity, policy, or practice that was the subject of the report. There is a rebuttable presumption that any termination or other adverse action that occurs more than 180 days after the date of such a report made is not a retaliatory action. Ariz. Rev. Stat. Ann. § 36-450.02(A) and (D).

What are the penalties?

The penalty for violating Ariz. Rev. Stat. § 20-463 is a civil penalty of not more than \$5,000 per violation. Ariz. Rev. Stat. § 20-466.02(C). The penalty for presenting prohibited claims to the state is a civil penalty not to exceed \$2,000 for each item or service claimed and an assessment of no more than twice the amount claimed for each item or service. Ariz. Rev. Stat. Ann. § 36-2918(B). Violating Ariz. Rev. Stat. § 44-1220, Arizona's trade and commerce law prohibiting fraudulent insurance claims, is a class 5 felony.

ARKANSAS

What are the Arkansas Medicaid Fraud False Claims Act, Arkansas Medicaid Fraud Act, & Arkansas Whistle-Blower 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, 2011.¹ In addition, Arkansas has a criminal statute, the Arkansas Medicaid Fraud Act ("AMFA") (Ark. Code Ann. §§ 5-55-101 to 5-55-114),² which provides for criminal sanctions in cases of Medicaid fraud. The AMFA became effective on December 31, 2005.³ Both acts were amended by the 2017 Arkansas Laws Act 978 (S.B. 564).⁴ Arkansas also has a Whistle-Blower Act ("AWBA") (Ark. Code. Ann. §§ 21-1-601 to 21-1-608).

Violations of the AMFFCA include: (1) knowingly making or causing to be made any false statement or representation of a material fact in any claim, request for payment, or application for any benefit or payment under the Arkansas Medicaid Program; (2) knowingly making or causing to be made any omission or false statement or representation of a material fact for use in determining rights to a benefit or payment under the Arkansas Medicaid Program; (3) having knowledge of the occurrence of any event affecting his or her initial or continued right to any benefit or payment or the initial or continued right to any benefit or payment of any other individual in whose behalf he or she has applied for or is receiving a benefit or payment, knowingly concealing or failing to disclose that event with an intent fraudulently to secure the benefit or payment either in a greater amount or quantity than is due or when no benefit or payment is authorized; (4) having made or submitted a claim, request for payment, or application to receive any benefit or payment for the use and benefit of another person and having received it, knowingly converting a benefit to a use other than for the use and benefit of another person; (5) knowingly presenting or causing to be presented a Medicaid claim for a physician's services while knowing that the individual who furnished the service was not licensed as a physician; (6) knowingly soliciting or receiving, any remuneration, including any kickback, bribe, or rebate, directly or indirectly, overtly or covertly, in cash or in kind: (A) In return for referring an individual to a person for the furnishing or arranging for the furnishing of any item

¹ S.B. 564 modifies nearly all the definitions under § 20-77-901, including additions of the terms "damages," "material," "managed care organization," "Medicaid provider," and "obligation."

² H.B. 1719, which passed on 4/11/2019, modifies the definition of "claim" and "illegal Medicaid participation;" expands criminal liability to include presenting a false claim knowing that the individual who furnished the service was not a properly licensed or credentialed provider; adds that where direct monetary loss doesn't exist or where it's difficult or impossible to determine the extent of the loss, the Attorney General may elect to seek a civil penalty based on the number of fraudulent claims submitted; adds that the state must give notice in the complaint whether it is seeking a civil penalty of \$500-\$10,000 for each claim or double damages; reduces liability for civil penalties if a person discovers an employee or subcontractor has committed a violation but cooperates with the investigation; allows the Department of Human Services to return all or a portion of lost funds to a managed care organization when permitted by the contract or rules; permits the Attorney General to apply to the court to seize and impound property where it appears that a person is or appears to be engaged in the transfer, conversion, or destruction of assets, records, or property in order to avoid paying restitution, fines, and civil penalties; permits the Attorney General to agree to a payment of up to 10% of the civil penalty as a reward in any settlement agreement for false claims but prohibits the use of restitution as a reward.

³ S.B. 564 modifies the definitions under § 5-55-102 including adding definitions for "managed care organization," "Medicaid provider," and "records." § 5-55-104: Defines responsibilities for Medicare providers to maintain all records for a period of at least 5 years from the date of claimed provision of any goods or services to any Medicaid recipient as well as penalties for noncompliance.

⁴ Effective August 1, 2017.

or service for which payment may be made in whole or in part under the program; or (B) In return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under the program; (7)(A) Knowingly offers or pays any remuneration, including any kickback, bribe, or rebate, directly or indirectly, overtly or covertly, in cash or in kind to any person to induce the person to: (i) Refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under the program; or (ii) purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under the program. (B) Subdivision (7)(A) of this section shall not apply to: (i) A discount or other reduction in price obtained by a provider of services or other entity under the program if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under the program; (ii) Any amount paid by an employer to an employee who has a bona fide employment relationship with the employer for employment in the providing of covered items or services; (iii) Any amount paid by a vendor of goods or services to a person authorized to act as a purchasing agent for a group of individuals or entities who are furnishing services reimbursed under the program, if: (a) The person has a written contract with each individual or entity which specifies the amount to be paid to the person, which amount may be a fixed amount or a fixed percentage of the value of the purchases made by each individual or entity under the contract; and (b) In the case of an entity that is a Medicaid provider as defined in § 20-9-101, the person discloses, in the form and manner as the Director of the Department of Human Services requires, to the entity and upon request to the director the amount received from each vendor with respect to purchases made by or on behalf of the entity; or (iv) Any payment practice specified by the director promulgated pursuant to applicable federal or state law; (8) knowingly makes or causes to be made or induces or seeks to induce any omission or false statement or representation of a material fact with respect to the conditions or operation of any institution, facility, or Medicaid provider in order that the institution, facility, or Medicaid provider may qualify to obtain or maintain any licensure or certification when the licensure or certification is required to be enrolled or eligible to deliver any healthcare goods or services to Medicaid recipients by state law, federal law, or the rules of the Arkansas Medicaid Program; (9) knowingly: (A) Charges for any service provided to a patient under the program money or other consideration at a rate in excess of the rates established by the state; or (B) Charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under the program, any gift, money, donation, or other consideration other than a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the patient: (i) As a precondition of admitting a patient to a hospital, nursing facility, or intermediate care facility for individuals with intellectual disabilities; or (ii) As a requirement for the patient's continued stay in the hospital, nursing facility, or intermediate care facility for individuals with intellectual disabilities when the cost of the services provided therein to the patient is paid for in whole or in part under the program; (10) Knowingly makes or causes to be made any omission or false statement or representation of a material fact in any application for benefits or for payment in violation of the rules, regulations, and provider agreements issued by the program or its fiscal agents; (11) Knowingly: (A) Participates, directly or indirectly, in the Arkansas Medicaid Program after having pleaded guilty or nolo contendere to or been found guilty of a charge of Medicaid fraud, theft of public benefits, or abuse of adults as defined in the Arkansas Criminal Code, § 5-1-101 et seq.; or (B) As a certified health provider enrolled in the Arkansas Medicaid Program pursuant to Title XIX of the Social Security Act or the fiscal agent of such a provider who employs, engages as an independent contractor, engages as a consultant, or otherwise permits the participation in the business activities of such a provider, any person who has pleaded guilty or nolo contendere to or has been found guilty of a charge of Medicaid fraud, theft of public benefits, or abuse of adults as defined in the Arkansas Criminal Code, § 5-1-101 et seq.; (12) Knowingly submits any false documentation supporting a claim or prior payment to the Office of Medicaid Inspector General or the Medicaid Fraud Control Unit within the office of the Attorney General during an audit or in response to a request for information or a subpoena; (13) Knowingly makes or causes to be made, or induces or seeks to induce, any material false statement to made to the Office of Medicaid Inspector General or the Medicaid Fraud Control Unit within the office of the Attorney General during an audit or in response to a request for information or a subpoena; (14) Knowingly forges the signature of a doctor or nurse on a prescription or referral for healthcare goods or services or submits a forged prescription or referral for healthcare goods or services in support of a claim for payment under the Arkansas Medicaid Program; (15) Knowingly places a false entry in a medical chart or medical record that indicates that healthcare goods or services have been provided to a Medicaid recipient knowing that the healthcare goods or services were not provided; (16) Knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval to the Arkansas Medicaid Program; (17) Knowingly makes, uses, or causes to be made or used a false record or statement that is material to a false

or fraudulent claim to the Arkansas Medicaid Program; (18) Knowingly: (A) Makes, uses, or causes to be made or used a false record or statement that is material to an obligation to pay or transmit money or property to the Arkansas Medicaid Program; or (B) Conceals or improperly avoids or decreases an obligation to pay or transmit money or property to the Arkansas Medicaid Program; or (19) Conspires to commit a violation of this section.⁵

Actions that violate the AMFA generally include the actions listed above under the AMFFCA. However, there are a few deviations. For example, conspiring to commit a violation is not included in the AMFA. Furthermore, the AMFFCA has slightly different language regarding the submission of a false or fraudulent claims and making false records or statements. In addition, Section 18 of the AMFFCA is not included as a violation of the AMFA.⁶ Additionally, violations under AMFFCA do not violate AMFA 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 but does not require proof of a specific intent to defraud. In contrast, the AMFA usually requires that a person act “purposely,” which means that a person had a “conscious object” to engage in unlawful conduct.⁷ 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 aggregate penalty recovered. Ark. Code Ann. §20-77-991 and § 5-55-113.

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

Like federal law, the AWBA^{8,9} 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. Similarly, in the private sector, Arkansas code prohibits retaliation, interference, coercion, or intimidation of individuals who oppose unlawful practices or testified, assisted, or participated in an investigation or proceeding. Ark. Code Ann. §16-123-108.

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. Violators will be penalized with a fine of \$5,000 to \$11,000 per claim and treble damages. However, the court may not assess less than two times the amount of damages which the state sustained because of the acts of the violator where the violator furnished the Attorney General’s office with all information known to the violator within 30 days of the date in which the violator first obtained the information and additional conditions are met. In

⁵ Ark. Code Ann. § 20-77-902.

⁶ A person is liable for a civil penalty under the AMFFCA if he or she knowingly: (A) Makes, uses, or causes to be made or used a false record or statement that is material to an obligation to pay or transmit money or property to the Arkansas Medicaid Program; or (B) Conceals or improperly avoids or decreases an obligation to pay or transmit money or property to the Arkansas Medicaid Program.

⁷ See 5-55-111(12) and (13) which are “knowingly,” instead of purposely.

⁸ Proposed legislation (H.B. 2183) would amend the definitions for “appropriate authority” and “whistle-blower.” H.B. 2183 died in House Committee at Sine Die Adjournment.

⁹ Effective August 1, 2017, H.B. 2055 established the opportunity for a public employee alleging retaliation to request an expedited hearing and, where there are findings of retaliation, create the specific remedies of reinstatement until the civil action is concluded or reinstatement and placement on paid leave until the civil action is concluded.

addition, any person violating the AMFFCA shall be liable for the Attorney General's reasonable expenses, including the cost of investigation, attorney's fees, court costs, witness fees and deposition fees. A violator may also be suspended from Medicaid or have its provider agreement revoked. Additionally, a violator of the act may be enjoined.

Medicaid fraud in violation of the AMFA is a Class C felony if the aggregate amount of payments illegally claimed is two thousand five hundred dollars (\$2,500) or more but less than five thousand dollars (\$5,000); a Class B felony if the aggregate amount of payments illegally claimed is five thousand dollars (\$5,000) or more but less than twenty-five thousand dollars (\$25,000); and a Class A felony if the aggregate amount of payments illegally claimed is twenty-five thousand dollars (\$25,000) or more.¹⁰ Illegal participation in the Medicaid program is also 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. Additionally, any person who is found guilty of or who pleads guilty or nolo contendere to Medicaid fraud shall pay one of the following fines: (1) if no monetary loss is incurred by the Arkansas Medicaid Program, a fine of between one and three thousand dollars for each omission or fraudulent act or claim; or (2) if a monetary loss is incurred by the Arkansas Medicaid program, a fine of an amount not less than the amount of monetary loss and no more than three (3) times the amount of monetary loss to the Arkansas Medicaid Program. However, the prosecuting attorney may waive these fines and the trier of fact may impose fines under Ark. Code. Ann. § 5-4-201. Any person found guilty of or who pleads guilty or nolo contendere to Medicaid fraud is required to additionally make full restitution to the Department of Human Services and the office of the Attorney General or prosecuting attorney for reasonable and necessary expenses incurred during investigation and prosecution.¹¹

CALIFORNIA

What laws in California serve the purpose of preventing the commission of fraud?

The California False Claims Act was enacted in 1987 and prohibits: (1) knowingly presenting or causing to be presented 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) conspiring to do any of these violations; (4) 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 or to any political subdivision, or knowingly concealing or knowingly and improperly avoiding, or decreasing an obligation to pay or transmit money or property to the state or to any political subdivision; and (5) as a beneficiary of an inadvertent submission of a false claim, subsequently discovering the falsity of the claim, and failing to disclose the false claim to the state or the political subdivision within a reasonable time after discovery of the false claim.¹² Cal. Gov't Code § 12651(a).

Additionally, California's Medi-Cal regulations prohibit: (1) with the intent to defraud, presenting for allowance or payment any false or fraudulent claim for furnishing Medi-Cal services or merchandise; (2) knowingly submitting false information for the purpose of obtaining greater compensation than that to which he or she is legally entitled for furnishing Medi-Cal services or merchandise; (3) knowingly submitting false information for the purposes of obtaining authorization for furnishing Medi-Cal services or merchandise; (4) knowingly and willfully executing or attempting to execute, a scheme or artifice to: (A) defraud the Medi-Cal program or any other health care program administered by the department or its agents or contractors, and/or (B) obtaining, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by or under the custody or control of the Medi-Cal program or any other

¹⁰ Amended by Arkansas Laws Act 978 (S.B. 564).

¹¹ Amended by Arkansas Laws Act 978 (S.B. 564). Effective August 1, 2017.

¹² California Assembly Bill 1270 proposes the following: that the materiality test focus on the potential effect of the false record or statement when it is made, not on the actual effect of the false statement when it is discovered; specifying that the amount of damages include consequential damages; applying the False Claims Act to claims, records, or statements made under the Revenue and Taxation code if certain conditions are met; specifying that relief for whistleblowers who have been retaliated against applies to any current or former employee, contractor, or agent; defining lawful acts entitled to whistleblower relief to include specific acts that may violate a contract, employment term, or duty owed to an employer or contractor.

administered by the department or its agents or contractors in connection with the delivery of or payment for health care benefits, services, goods, supplies, or merchandise. Cal. Welf. & Inst. Code § 14107(b).

In addition to the above, California's penal code prohibits aiding, abetting, soliciting, or conspiring with any person to: (1) Knowingly present or cause to be presented any false or fraudulent claim for the payment of a loss or injury, including payment of a loss or injury under a contract of insurance; (2) Knowingly present multiple claims for the same loss or injury, including presentation of multiple claims to more than one insurer, with an intent to defraud; (3) Knowingly prepare, make, or subscribe any writing, with the intent to present or use it, or to allow it to be presented, in support of any false or fraudulent claim; (4) Knowingly make or cause to be made any false or fraudulent claim for payment of a health care benefit; (5) Knowingly submit a claim for a health care benefit that was not used by, or on behalf of, the claimant; (6) Knowingly present multiple claims for payment of the same health care benefit with an intent to defraud; (7) Knowingly present for payment any undercharges for health care benefits on behalf of a specific claimant unless any known overcharges for health care benefits for that claimant are presented for reconciliation at that same time. Cal. Penal Code § 550(a). Additionally, it prohibits knowingly assisting or conspiring with any person to present, cause to be presented, prepare, or make any written or oral statement as part of, or in support of opposition to, a claim for payment or other benefit pursuant to an insurance policy, knowing that the statement contains any false or misleading information concerning any material fact. Cal. Penal Code § 550(b).

What are the Qui Tam Provisions and Whistleblower Protections?

The California False Claims Act permits *qui tam* actions. California Gov't Code § 12652(c)(1). If the state or political subdivision proceeds with an action brought by the *qui tam* plaintiff, the *qui tam* plaintiff shall receive at least 15 percent but not more than 33 percent of the proceeds or settlement of the claim, depending on the extent to which the *qui tam* plaintiff substantially contributed to the prosecution of the action. *Id.* at (g)(2). If the state or political subdivision does not proceed with an action, the *qui tam* plaintiff shall receive not less than 25% and not more than 50% of the proceeds of the action or settlement. *Id.* at (g)(3).

Regardless of whether the state proceeds with the action, if the court finds that the action was brought by a person who planned and initiated the violation upon which the action was brought, then the court may, to the extent the court considers appropriate, reduce the share of the proceeds of the action that the person would otherwise receive, taking into account the role of that person in advancing the case to litigation and any relevant circumstances pertaining to the violation. The court shall not award the *qui tam* plaintiff more than 33% of the proceeds if the state or political subdivision goes forth with the action or 50% if the state or political subdivision declines to go forth, taking into account the significance of the information, the role of the *qui tam* plaintiff in advancing the case to litigation, the scope of the person's involvement in the fraudulent activity, the person's attempts to avoid or resist the activity, and all other circumstances surrounding the activity. *Id.* at (g)(5).

California law provides the following protections for whistleblowers: Any employee, contractor, or agent shall be entitled to all relief necessary to make that him, if that individual is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of his or her employment because of lawful acts done by him or associated others in furtherance of a false claims action or other efforts to stop one or more violations of the California false claims act. Cal. Gov't Code § 12653(a). The whistleblower is entitled to relief that includes reinstatement with the same seniority status that he would have had but for the discrimination, 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, and where appropriate, punitive damages. The defendant shall also be required to pay litigation costs and reasonable attorneys' fees. An action under this section may be brought in the appropriate superior court of the state. Cal. Gov't Code § 12653(b). The statute of limitations on a retaliation claim is three years after the date when the retaliation occurred. Cal. Gov't Code § 12653(c).

What are the penalties?

A civil action brought for violations of the California False Claims Act must be filed within six years of the violation or three years after the material facts were or should have known to the Attorney General, but not more than 10 years after the violation. Cal Gov't Code § 12654. Violators of the California False Claims Act are liable for two to three times the

amount of damages that the state or political subdivision sustains because of the act of that person. Additionally, for violation of items (1)-(3) listed above, violators are also liable to the state for the costs of the civil action brought to recover those penalties or damages, as well as a penalty of no less than \$5,500 and no more than \$11,000 for each violation. However, the court may assess not less than two times and not more than three times the amount of damages sustained by the state because of the violator's actions and no civil penalty if the court finds all of the following: (1) the person committing the violation gave officials responsible for investigating false claims violations with all information known to that person about the violation within 30 days after the date on which the person first obtained the information; (2) the person fully cooperated with any investigation by the state regarding the violation; (3) at the time the person furnished the state with information about the violation, no criminal prosecution, civil action, or administrative action had commenced with respect to the violation and the person did not have actual knowledge of the existence of an investigation into the violation. Cal. Gov't. Code § 12651(b).

For a violation of the Medi-Cal false claims prohibition, the penalty is up to five years of imprisonment and/or a fine of up to treble damages. Cal. Welf. & Inst. Code § 14107(a).

For the first three violations of the California penal code listed above and knowingly assisting or conspiring with any person to present, cause to be presented, prepare, or make any written or oral statement as part of, or in support of opposition to, a claim for payment or other benefit pursuant to an insurance policy, knowing that the statement contains any false or misleading information concerning any material fact, violators are guilty of a felony punishable by imprisonment for two, three, or five years and by a fine not exceeding \$50,000 or whichever is greater. Violators who are guilty of prohibited conduct related to health care benefits listed above are guilty of a public offense. When the claim or amount at issue is greater than \$950, the offense is punishable by imprisonment for up to five years, or by a fine not exceeding \$50,000 or double the amount of the fraud, whichever is greater, or by both that imprisonment and fine, or by imprisonment in a county jail for less than a year, by a fine of not more than \$10,000, or both that imprisonment and fine. When the aggregate amount of the claims at issue is less than \$950, the offense is punishable by imprisonment in a county jail for less than six months, or by a fine of not more than \$1,000, or by both that imprisonment and fine. Cal. Penal Code § 550(c)(1) and (3). Lastly, restitution shall be ordered for a person convicted of violating this section of the penal code. The amounts and recipients of the restitution will be determined by the court. Cal. Penal Code § 550(c)(4).

COLORADO

What are the Colorado laws prohibiting false claims?

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. Rev. 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, a false or fraudulent claim for payment or approval of a Medicaid claim; (2) knowingly making, using, or causing to be made or used a false record or statement material to a false or fraudulent Medicaid 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.

Colorado's Medicaid Fraud Control statute (Colo. Rev. Stat. Ann. § 24-31-801 *et seq.*) also prohibits knowing and willfully, with the intent to defraud, making a claim, statement, or representation or causing it to be made for use in obtaining authorization to provide a good or service that contains material information that is false: for use by another in obtaining a good or service under the Medicaid program or for use in qualifying as a provider of a good or service under the Medicaid program; signing or submitting a provider application with knowledge that it contains material information that is false by commission or omission; charging Medicaid beneficiaries in excess of Medicaid program rates; falsifying or concealing any records that are required to fully disclose the nature of all goods or services for which the claim was submitted or reimbursement was received, including destroying or removing the records or failing to maintain them as required by law for a period of at least six years after the date on which payment was received; and altering, falsifying, or concealing any records that are required to disclose fully all income and expenditures upon which rates of reimbursement were based, or destroying or removing the records with the intent to prevent their review by the state.

Lastly, Colorado's criminal code prohibits presenting an insurance claim containing false material information or withholding material information with the intent to defraud. Colo. Rev. Stat. Ann. § 18-5-211(b).

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 a claim is filed under the CMFCA, 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. Colo. Rev. Stat. Ann. § 25.5-4-306(4).

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. Colo. Rev. Stat. Ann. § 25.5-4-306(7).

What are the penalties?

Claims for violation of the CMFCA must be brought within six years of the violation or three years after the material facts were known or should have been known to the Attorney General, but not more than 10 years after the violation. Colo. Rev. Stat. Ann. § 25.5-4-307(1). The CMFCA establishes per claim financial penalties of \$5,500 to \$11,000,¹³ 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. Colo. Rev. Stat. Ann. § 25.5-4-305. Claims for violation of the Medicaid Fraud Control statute must be brought within three years after the date of discovery of the offense, but no later than six years after the date of the offense being committed. Colo. Rev. Stat. Ann. § 24-31-811.

Criminal Penalties for Violation of Colorado's Medicaid Fraud Control Statute

¹³ Except that these upper and lower limits on liability shall automatically increase to equal the civil penalty allowed under the Federal False Claims Act, if and as the penalties in such federal act may be adjusted for inflation.

<i>Prohibited Activity Citation</i>	<i>Prohibited Activity</i>	<i>Aggregate Amount of Payments</i>	<i>Criminal Offense</i>
(1)(a)-(c) or 1(f)	Knowingly and willfully, with intent to defraud, making a claim containing materially false information; knowingly and willfully, with intent to defraud, making a false statement in order to obtain authorization for a good or service; knowingly and willfully, with intent to defraud, making a statement or representation for use by another in obtaining a Medicaid good or service	Less than \$50	Class 1 Petty Offense
		>\$50 but <\$300	Class 3 Misdemeanor
		>\$300 but <\$750	Class 2 Misdemeanor
		>\$750 but <\$2,000	Class 1 Misdemeanor
		>\$2,000 but <\$5,000	Class 6 Felony
		>\$5,000 but <\$20,000	Class 5 Felony
		>\$20,000 but <\$100,000	Class 4 Felony
		>\$100,000 but <\$1,000,000	Class 3 Felony
>\$1,000,000	Class 2 Felony		

Violation of Colorado’s insurance fraud statute is a class 5 felony. Colo. Rev. Stat. Ann. § 18-5-211(4).

GEORGIA

What are the Georgia False Medicaid Claims Act, the Georgia Taxpayer Protection False Claims Act, and the Georgia Medical Assistance Act of 1977?

The Georgia False Medicaid Claims Act (“GFMCA”) (Ga. Code Ann. § 49-4-168 *et seq.*) became effective on May 24, 2007. Violations of the GFMCA include actions by natural persons or legal entities capable of being sued that (1) knowingly present or cause to be presented to the Georgia Medicaid program 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) conspiring to commit a violation of sections (1), (2), (4), (5), (6), or (7) listed here; (4) having possession, custody, or control of property or money used or to be used by the Georgia Medicaid program and knowingly delivering or causing to be delivered less than all of such property or money; (5) being authorized to make or deliver a document certifying receipt of property used (or to be used) by the Georgia Medicaid program and, intending to defraud the Georgia Medicaid program, making or delivering the receipt 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 from an officer or employee of the Georgia Medicaid program who lawfully may not sell or pledge the property; or (7) knowingly making, using, or causing to be made or used a false record or statement material to an obligation to pay or transmit property or money to the Georgia Medicaid program, or knowingly concealing or knowingly and improperly avoiding or decreasing an obligation to pay or transmit property or money to the Georgia Medicaid program.

The Georgia Taxpayer Protection False Claims Act (“GTPFCA”) (Ga. Code Ann. § 23-3-120 *et seq.*) became effective April 24, 2013. The GTPFCA’s defined violations mirror that of the GFMCA but expand liability by applying them to situations where the state and local governments are the payers or owners of the property.

The Georgia Medical Assistance Act of 1977 (“GMAA”)(Ga. Code Ann. § 49-4-140) became effective January 1, 2010. Violations of the GMAA include: (1) obtaining, attempting to obtain, or retaining for oneself or any other person any medical assistance or other benefits under this article, or under a managed care program operated, funded, or reimbursed by the Georgia Medicaid program, to which the person or provider is not entitled, or in an amount greater than that to which the person or provider is entitled, when the assistance, benefit, or payment is obtained, attempted to be obtained, or retained, by: (A) knowingly and willfully making a false statement or false representation, (B) deliberate concealment of any material fact; or (C) any fraudulent scheme or device; (2) knowingly and willfully accepting medical assistance payments to which he or she is not entitled or in an amount greater than that to which he or she is entitled or knowingly and willfully falsifying any report or document required under this act.

Georgia Code Ann. § 16-10-20 and § 16-10-21 both expand liability for false claims violations by penalizing concealment of falsified material facts and conspiracy to steal government property, respectively. Conspiracy to steal government property is defined as conspiring or agreeing with another to commit theft of property of the state or political subdivision or any agency thereof or which is under the control or possession of a state officer or employee in his official capacity. The crime is complete when the conspiracy or agreement is effected and an overt act in furtherance thereof has been committed, regardless of whether the theft is consummated.

The Georgia Insurance Code (“GIC”)(Ga. Code Ann. § 33-1-9) became effective May 13, 2004. A natural person violates the GIC when he/she knowingly or willfully: makes or aids in the making of any false or fraudulent statement or representation of any material factor or thing in any written statement or certificate and in the filing of a claim for the purpose of procuring or attempting to procure the payment of any false or fraudulent claim or other benefit by an insurer. The code additionally prohibits a natural person knowingly and willfully with the intent to defraud subscribing, making, or concurring in making any annual or other statement required by law to be filed with the Commissioner containing any material statement which is false. The code specifically states that a person commits a “fraudulent insurance act” if he: (1) Knowingly and with intent to defraud presents, causes to be presented, or prepares with knowledge or belief that it will be presented, to an insurer, purported insurer, broker, or any agent thereof, any written statement as part of, or in support of a claim for payment or other benefit pursuant to an insurance policy, which he knows to contain materially false information concerning any fact material or if he conceals, for the purpose of misleading another, information concerning any fact material thereto; or (2) Knowingly and willfully transacts any contract, agreement, or instrument which violates the Georgia Insurance Code.

What are the Qui Tam Provisions and Whistleblower Protections?

The GMFCA and the GTPFCA both contain provisions that allow individuals (or *qui tam* plaintiffs) to file a lawsuit to enforce the laws on behalf of the state. Prior to the expiration of the 60-day period for which the complaint is under seal, the Attorney General will either proceed with the civil action or notify the court that it declines to take over the civil action, in which case the *qui tam* plaintiff has the right to proceed with the action. 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. 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, depending on the extent to which the *qui tam* plaintiff contributes to the prosecution of the lawsuit. 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. Under the GTPFCA, however, a *qui tam* plaintiff may only bring the lawsuit upon the written approval of the Attorney General.¹⁴ Additionally, the GTPFCA does not permit a current or former public employee or public official¹⁵ to bring a

¹⁴ S.B. 58 proposes removing this requirement.

qui tam lawsuit if the allegations the action are substantially based upon: (1) allegations of wrongdoing or misconduct which the individual had a duty or obligation to report or investigate within the scope of his or her public employment or office; or (2) information or records to which the individual had access as a result of his or her public employment or office.

The GMFCA and GTPFCA protect employees, contractors, or agents who have been discharged, demoted, suspended, threatened, harassed, or discriminated against in another manner because they took lawful acts to stop a violation of the GMFCA and GTPFCA. These individuals 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 GMFCA or GTPFCA may not be brought more than three years after the date when the discrimination occurred.

What are the Penalties?

The GMFCA imposes penalties consistent with the civil penalties provision of the FCA plus three times the amount of damages which the Georgia Medicaid program sustains because of the violator's actions. Additionally, violators are liable to the state for all costs of any civil action brought to recover the damages and penalties. The court may assess not more than two times the amount of the actual damages sustained by the Georgia Medicaid program as the result of the violator's actions if the violator furnished officials of the Georgia Medicaid program with all information known to him/her about the violation within 30 days after the date on which the defendant first obtained the information, the violator fully cooperated with any government investigation of the violation, and at the time the violator furnished the Georgia Medicaid program with the information, no criminal prosecution, civil action, or administrative action had commenced regarding the violation and the violator did not have actual knowledge of the existence of an investigation into the violation. Ga. Code Ann. § 49-4-168(b).

The GTPFCA imposes a civil penalty of not less than \$5,500 and not more than \$11,000 for each false or fraudulent claim, plus three times the amount of damages which the state or local government sustains because of the violator's actions.

In addition to criminal penalties, the GMAA imposes a fine of not more than \$10,000 per offense. Where the defendant is convicted of abuse (when a provider knowingly obtains or attempts to obtain medical assistance or other benefits or payments to which the provider knows he or she is not entitled when the assistance, benefits, or payments are greater than what would have been paid according to the department's policies and procedure manuals and the assistance, benefits, or payments directly or indirectly result in unnecessary costs to the medical assistance program), penalties of two times the amount of any excess benefit or payment are imposed. Each person guilty of a violation shall be liable for a civil penalty equal to the greater of (1) three times the amount of the excess benefit or payment or (2) \$1,000 for each excessive claim for assistance, benefit, or payment. Additionally, interest on the penalty shall be paid at the rate of 12 percent per annum from the date of payment of any such excessive amount or from the date of receipt of any claim for an excessive amount when no payment has been made until the date of payment of such penalty to the department. Furthermore, any property which is directly or indirectly obtained by a person or entity through or as a result of Medicaid fraud in the provision of services or equipment shall be subject to civil forfeiture proceedings. Finally, a provider's ability to participate in the Medicaid program may be affected. The department may refuse to accept a statement of participation, deny a request for reinstatement, refuse to exercise its option to renew a statement of participation, suspend or withhold those payments arising from fraud or willful misrepresentation under the Medicaid program, or terminate the participation of any provider other than a natural person or a natural person if that provider or any person with an ownership or control interest or any agent or managing employee of such provider has been convicted of a violation under the act.

The penalties for concealment of false claims under Ga. Code Ann. § 16-10-20 is a fine of not more than \$1,000 or imprisonment for not less than one nor more than five years, or both.

¹⁵ The term "public employee," "public official," and "public employment include federal, state, and local employees and officials.

Under Ga. Code Ann. § 16-10-21, a person convicted of the offense of conspiracy to defraud the state shall be punished by imprisonment for a sentence of one to five years.

Violators of the Georgia Insurance Code will be convicted of a felony and punished by imprisonment for a sentence of two to ten years, or by a fine of not more than \$10,000, or both.

IOWA

What are the Iowa False Claims Act, the Iowa Medical Assistance Act, and the Iowa Insurance Fraud Act?

The Iowa False Claims Act (“IFCA”) (Iowa Code Ann. §§ 685.1 to 685.7) is a civil statute designed to help the state government combat fraud and recover losses resulting from fraud against public agencies. The Iowa Medical Assistance Act (“IMAA”)(Iowa Code Ann. § 249A.47) additionally deters providers from improperly filing claims by imposing sanctions. The IMAA became effective July 1, 2014. While the IFCA and IMAA are specific to public agencies and Medicaid, the Iowa Insurance Fraud Act (IIFA) authorizes the insurance fraud bureau to investigate allegations of insurance fraud and sets out penalties for filing false claims with any insurer. Iowa Code Ann. § 507E.1-507E.8.

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 knowingly delivering or causing to be delivered 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, or receiving as a pledge of an obligation or debt, 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 making or using a false record or statement material to an obligation to pay or transmit money or property to the state or 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.

The IMAA deems all of the following scenarios as violations: (a) a person who intentionally and purposefully presents or causes to be presented to the department a claim that the department determines meets any of the following criteria: (1) a claim for medical or other items or services that the provider knows was not provided as claimed, including a claim by any provider who engages in a pattern or practice of presenting or causing to be presented a claim for an item or service that is based on a billing code that the provider knows will result in a greater payment to the provider than the billing code the provider knows is applicable to the item or service actually provided; (2) a claim for medical or other items or services the provider knows to be false or fraudulent; (3) a claim for a physician service or an item or service incident to a physician service by a person who knows that the individual who furnished or supervised the furnishing of the service meets any of the following: (i) was not licensed as a physician; (ii) was licensed as a physician, but such license had been obtained through a misrepresentation of material fact; (iii) represented to the patient at the time the service was furnished that the physician was certified in a medical specialty by a medical specialty board when the individual was not so certified; (4) a claim for medical or other items or services furnished during a period in which the provider was excluded from providing such items or services; (5) a claim for a pattern of medical or other items or services that a provider knows were not medically necessary.

Violations of the IIFA include: with the intent to defraud an insurer, (1) presenting or causing to be presented to an insurer, any written document or oral statement, including a computer-generated document, as part of, or in support of, a claim for payment or other benefit pursuant to an insurance policy, knowing that such document or statement contains any false information concerning a material fact; and (2) assisting, abetting, soliciting, or conspiring with another to present or cause to be presented to an insurer, any written document or oral statement, including a computer-generated document, that is intended to be presented to any insurer in connection with, or in support of, any claim for payment or other benefit pursuant to an insurance policy, knowing that such document or statement contains any false information concerning a material fact. Iowa Code Ann. § 507E.3(2)(a)-(b).

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. Iowa Code Ann. § 685.3. 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 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. 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 court finds that the action was brought by a *qui tam* plaintiff who planned and initiated the violation upon which the action was brought, the court may, to the extent it considers appropriate, reduce the share of the proceeds of the action to which the *qui tam* plaintiff would otherwise receive, taking into account the role that the *qui tam* plaintiff in advancing the case to litigation and any relevant circumstances pertaining to the violation. If the *qui tam* plaintiff is convicted of criminal conduct arising from his role in the violation, he shall be dismissed from the action and shall not receive any share of the proceeds of the action.

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 violation¹⁶ 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. Iowa Code Ann. § 685.2(1).

The IMAA provides for a civil penalty of not more than \$10,000 for each item or service. Iowa Code Ann. § 249A.47(1)(a). Providers are subject to a civil penalty of not more than \$50,000 for each false record or statement. Iowa Code Ann. § 249A.47(1)(g). Additionally, violators may be assessed not more than three times the amount claimed for each item or service in lieu of damages sustained by the department because of each claim. Iowa Code Ann. § 249.47(2)(a). Violation of the IIFA is a class D felony. Iowa Code Ann. 507E.3(2).

Additionally, violating any provision of the IFCA, IMAA, any rule promulgated pursuant thereto, or any federal or state false claims act is considered appropriate grounds for the Iowa Department of Human Services (the "Department") to impose sanctions against any person (any individual human being, company, provider, provider affiliate, or other legal entity). Sanctions may include probation, suspension, or termination for participation in the medical assistance program, suspension of payments in whole or in part, prior authorization of services, and review of claims prior to payment. The Department shall consider the totality of the circumstances in determining sanctions to be imposed, based on several enumerated factors. Iowa Admin. Code r. 441-79.2(249A)(79.2)(1)-(4).

¹⁶ Except that these upper and lower limits on liability shall automatically increase to equal the civil penalty allowed under the Federal False Claims Act, if and as the penalties in such federal act may be adjusted for inflation.

KANSAS

What are the Kansas False Claims Act, the Kansas Medicaid Fraud Control Act, & the Kansas Fraudulent Insurance 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.^{17,18} The KFCA became effective on April 30, 2009. In addition, Kansas has a Medicaid Fraud Control Act (“KMFCA”) which became effective on July 1, 2011 (Kan. Stat. Ann. § 21-5925 to 21-5934; 75-725; 75-726). Kansas also enacted the Kansas Fraudulent Insurance Act (“KFIA”)(Kan. Stat. Ann. § 40-2,118)¹⁹ which became effective on July 1, 2011.²⁰

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

¹⁷ Proposed amendment (H.B. 2337) to Kan. Stat. Ann. §§ 75-7501 through 75-7506 was introduced on February 9, 2017. The amendment would modify (additions in underline and strikethrough as follows) the definition of “claim” to “include[s] any request or demand, whether under contract or otherwise, for money, property, or services, regardless of whether the state or any political subdivision thereof has title to the money or property, that is made to any employee, officer or agent of the state or any political subdivision thereof or made to any contractor, grantee or other recipient if: (1) The money, property or service is to be spent or used on behalf of the state or any political subdivision thereof or to advance a program or interest of the state or any political subdivision thereof; and (2) the state or any political subdivision thereof: (A) Provides any portion of the money, property or services which is requested or demanded; (B) will reimburse such contractor, grantee or other recipient for any portion of the money or property which is requested or demanded.” The amendment would add that proof of specific intent to defraud is not required. It would also add a definition of “material” as “having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property.” It additionally proposes to add a definition of “obligation” as “an established duty, whether or not fixed, arising from an express or implied contractual, grantor-grantee or licensor-licensee relationship, from a fee-based or similar relationship, from statute, rule or regulation or from retention of any overpayment.” It would make several modifications to the definition of “unlawful act” under the statute in § 75-7503. Proposes changing the trigger event for the statute of limitations in § 75-7505(a)(2) as follows: “more than 3 years after the date on which the facts material to the right of action are known or reasonably should have been known by the attorney general, but in no even more than 10 years after the date on which the violation was committed, whichever occurs last.” Proposes amending § 75-7505(b) to read “A civil action for a violation of K.S.A. 2016 Supp. 75-7503, and amendments thereto, may be brought for activity prior to the effective date of this act, or for activity prior to the effective date of any amendments thereto, if the limitation period set in subsection (a) has not lapsed.” Proposes additional language modifications to § 75-7505. Proposes expanding the protections of § 75-7506 by making the following modifications: “(a) A person, including an employee, contractor or agent who is discharged, demoted, suspended, threatened, harassed or in any other manner retaliated against in the terms and conditions of employment because of a lawful act undertaken by the person or associated others in furtherance of an action under this act, or other efforts to stop one or more violations of this act, including investigation for, initiation of, testimony for, or assistance in an action filed or to be filed under this act, shall be 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 fees.” Proposes adding a statute of limitation of three years after the date on which the retaliation occurs. H.B. 2337 died in committee 5/4/2018.

¹⁸ H.B. 2375 was introduced on Feb. 19, 2019 and proposes: adding a section to provide for suits by *qui tam* relators; defining “original source” and “obligation”; raising the minimum civil penalty from \$1,000 to \$5,000; tying the civil penalty amounts to the amounts in the federal False Claims Act; adding that violators are liable to *qui tam* relators for all reasonable costs and attorneys’ fees incurred in bringing an action; adding that false claims that are knowingly submitted for payment or approval shall be actionable, regardless of whether the state actor is proved to have been misled; providing for whistleblower relief; providing for distribution of recovery for cases brought by both *qui tam* relators and by the government alone.

¹⁹ Kan. Stat. Ann. § 40-2,118a was repealed effective July 1, 2019.

²⁰ H.B. 2213, introduced on February 8, 2019, proposes adding definitions for “amount involved” and “pecuniary harm.”

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 involve, with the intent to defraud, making, presenting, submitting, offering or causing to be made, presented, submitted, or offered: (A) any false or fraudulent claim for payment for any goods, service, item, facility, or accommodation for which payment may be made, in whole or in part, under the Medicaid program, whether or not the claim is allowed or allowable; (B) any false or fraudulent statement or representation for use in determining payments which may be made, in whole or in part, under the Medicaid program, whether or not the claim is allowed or allowable; (C) 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, facility, or accommodation, for which payment may be made, in whole or in part, under the Medicaid program, whether or not the claim is allowed or allowable; (D) 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 for which payment may be made, in whole or in part, under the Medicaid program, whether or not the claim is allowed or allowable; (E) any statement or representation for use by another in obtaining any goods, service, item, facility, or accommodation for which payment may be made, in whole or in part, under the Medicaid program, knowing the statement or representation to be false, in whole or in part, by commission or omission, whether or not the claim is allowed or allowable; (F) any claim for payment, for any goods, service, item, facility, or accommodation, which is not medically necessary in accordance with professionally recognized parameters or as otherwise required by law, for which payment may be made, in whole or in part, under the Medicaid program, whether or not the claim is allowed or allowable; (G) any wholly or partially false or fraudulent book, record, document, data or instrument, which is required to be kept or which is kept as documentation 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 for which payment is, has been, or can be sought, in whole or in part, under the Medicaid program, whether or not the claim is allowed or allowable; (H) 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 Kansas department for aging and disability services, Kansas department of health and environment, 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; (I) 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 Medicaid program; or (J) intentionally executing or attempting to execute a scheme or artifice to defraud the Medicaid program or any contractor or subcontractor thereof.²¹

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.

The KFIA *does not* contain such provisions.

²¹ H.B. 2040 was introduced on January 22, 2019 and proposes increasing felony loss thresholds for certain property crimes from \$1,000 to \$1,500.

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 may reduce damages for violations if the false claims are voluntarily disclosed.

In addition to any other criminal penalties provided by law, any person convicted of a violation of the KMFCA may be liable for all of the following: (1) payment of full restitution of the amount of the excess payments; (2) payment of interest on the amount of any excess payments at the maximum legal rate in effect on the date the payment was made to the person for the period from the date upon which payment was made, to the date upon which repayment is made; and (3) payment of all reasonable expenses that have been necessarily incurred in the enforcement of the KMFCA including, but not limited to, the costs of the investigation, litigation, and attorney fees. In addition to any other criminal penalties provided by law, any person convicted of a violation of the KMFCA 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. Penalties provided by the KMFCA "are not intended to be exclusive remedies and do not preclude the use of any other criminal or civil remedy."

Each individual count of Medicaid fraud, defined in sections (A)-(G) and (J) under the KMFCA, is classified as follows: (i) a severity level 3, nonperson felony if the payments illegally claimed are \$250,000 or more; (ii) a severity level 5, nonperson felony if the payments illegally claimed are between \$100,000 and \$250,000; (iii) a severity level 7, nonperson felony if the payments illegally claimed are between \$25,000 and \$100,000; (iv) a severity level 9 nonperson felony if the payments illegally claimed are between \$1,000²² and \$25,000; and (v) a class A nonperson misdemeanor if the payments illegally claimed are less than \$1,000²³. Additionally, when great bodily harm results from such a fraudulent act, regardless of the aggregate amount of payments illegally claimed, Medicaid fraud is classified as a severity level 4, person felony, and when death results from such a fraudulent act, regardless of the aggregate amount of payments illegally claimed, Medicaid fraud is a severity level 1, person felony. When Medicaid fraud, as defined in (H)-(I) of the KMFCA occurs, it is considered a severity level 9, nonperson felony. The KMFCA also provides that a person who violates the provisions of the KMFCA may also be prosecuted for, convicted of, and punished for any form of battery or homicide. Kan. Stat. Ann. § 21-5927.

Violations of the KFIA are considered to be "a severity level 6, nonperson felony if the amount involved is \$25,000 or more; a severity level 7, nonperson felony if the amount is at least \$5,000 but less than \$25,000; a severity level 8, nonperson felony if the amount is at least \$1,000 but less than \$5,000; and a class C nonperson misdemeanor if the amount is less than \$1,000. Any combination of fraudulent acts as defined in subsection (a) which occurs in a period of six consecutive months which involves \$25,000 or more shall have a presumptive sentence of imprisonment regardless of its location on the sentencing grid block." Furthermore, in addition to any other penalty, a person who violates the KFIA shall be ordered to make restitution to the insurer or any other person or entity for any financial loss sustained as a result of such violation.

KENTUCKY

What laws in Kentucky prohibit insurance fraud and abuse?

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.

²² Signed into law 6/9/2017, legislation (H.B. 2092) amends this amount to \$1,500.

²³ Signed into law 6/9/2017, legislation (H.B. 2092) amends this amount to \$1,500.

Violations of the KCFA²⁴ 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 the Cabinet for Health and Family Services, or intentionally engaging 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 falsifying, concealing, or covering up by any trick, scheme, or device a material fact, or making any false, fictitious, or fraudulent statement or representation, or making or use any false writing or document knowing the same to contain any false, fictitious, or fraudulent statement or entry.

Additionally, Kentucky's Insurance Code prohibits: (1) knowingly, and with the intent to defraud or deceive, presenting, causing to be presented, or preparing with the knowledge or belief that it will be presented to an insurer, the Kentucky Claims Commission, Special Fund, or any agent thereof any written or oral statement as part of, or in support of, a claim for payment or other benefit pursuant to an insurance policy or from a "self-insurer," knowing that the statement contains any false, incomplete, or misleading information concerning any fact or thing material to a claim; (2) knowingly and willfully transacting any contract, agreement, or instrument in violation of the Code; and (3) assisting, abetting, soliciting, or conspiring with another to commit a fraudulent insurance act in violation of the Code. Ky. Rev. Stat. Ann. § 304.47-020.

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.

²⁴ The implementing regulations issued by the Cabinet for Health and Family Services – Department for Medicaid Services expands upon this notion as follows: "Unacceptable practice" means conduct by a provider which constitutes "fraud" or "provider abuse" as defined in KRS 205.8451(2) or (8), or willful misrepresentation, and includes the following practices: (a) Knowingly submitting, or causing the submission of false claims, or inducing, or seeking to induce, a person to submit false claims; (b) Knowingly making, or causing to be made, or inducing, or seeking to induce, a false, fictitious or fraudulent statement or misrepresentation of material fact in claiming a Medicaid payment, or for use in determining the right to payment; (c) Having knowledge of an event that affects the right of a provider to receive payment and concealing or failing to disclose the event or other material omission with the intention that a payment be made or the payment is made in a greater amount than otherwise owed; (d) Conversion; (e) Soliciting or accepting bribes or kickbacks; (f) Failing to maintain or to make available, for purposes of audit or investigation, administrative and medical records necessary to fully disclose the medical necessity for the nature and extent of the medical care, services and supplies furnished, or to comply with other requirements established in 907 KAR 1:673, Section 2; (g) Knowingly submitting a claim or accepting payment for medical care, services, or supplies furnished by a provider who has been terminated or excluded from the program; (h) Seeking or accepting additional payments, for example, gifts, money, donations, or other consideration, in addition to the amount paid or payable under the Medicaid Program for covered medical care, services, or supplies for which a claim is made; (i) Charging or agreeing to charge or collect a fee from a recipient for covered services which is in addition to amounts paid by the Medicaid Program, except for required copayments or recipient liability, if any, required by the Medicaid Program; (j) Engaging in conspiracy, complicity, or criminal syndication; (k) Furnishing medical care, services, or supplies that fail to meet professionally recognized standards, or which are found to be noncompliant with licensure standards promulgated under KRS Chapter 216B and failing to correct the deficiencies or violation as reported to the department by the Office of Inspector General, for health care or which are beyond the scope of the provider's professional qualifications or licensure; (l) Discriminating in the furnishing of medical care, services, or supplies as prohibited by 42 U.S.C. 2000d; (m) Having payments made to or through a factor, either directly or by power of attorney, as prohibited by 42 CFR 447.10; (n) Offering or providing a premium or inducement to a recipient in return for the recipient's patronage of the provider or other provider to receive medical care, services or supplies under the Medicaid Program; (o) Knowingly failing to meet disclosure requirements; (p) Unbundling as defined under subsection (40) of this section; or (q) An act committed by a nonprovider on behalf of a provider which, if committed by a provider, would result in the termination of the provider's enrollment in the program. 907 Ky. Admin. Regs. § 1:671(Section 1)(40). Section 3 of the regulations sets forth the administrative process for identification and referral of unacceptable practices as defined by this part. Sections 4-6 of the regulations set forth possible consequences and sanctions, which include but are not limited to possible termination of a provider's participation and a period of exclusion if an administrative determination is made, that provider engaged in an unacceptable practice. 907 Ky. Admin. Regs. § 1:671(Section 5)(4)-(6).

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.

The Insurance Code does not contain a *qui tam* provision. However, it contains a private right of action for any person damaged as a result of a violation of the Insurance Code. This plaintiff may recover compensatory damages, plus all reasonable investigation and litigation expenses, including attorneys' fees, at the trial and appellate courts.

What are the Penalties?

The criminal penalties for violating the KFCA include the following: any person 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 \$300²⁵, the violation is classified Class D felony. Further, any person who violates subsection (3) is guilty of a Class C felony. Lastly, any person 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 plus interest; (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; and (5) be removed as a participating provider in the Medical Assistance Program for 2 months to 6 months for a first offense, for 6 months to 1 year for a second offense, and for 1 year to 5 years for a third offense. The remedies under the KFCA are separate from and cumulative to any other administrative, civil, or criminal remedies available under federal or state law or regulation.

Violations of the Insurance Code are a Class A misdemeanor unless the aggregate of the claim, benefit, or money is: (1) \$500-\$10,000, in which case it is a Class D felony; (2) \$10,000-\$1,000,000, in which case it is a Class C felony; or more than \$1,000,000, in which case it is a Class B felony. A person, with the purpose to establish or maintain a criminal syndicate or to facilitate any of its activities, is guilty of organized crime, a Class B felony, if he or she engages in activities set forth in Ky. Rev. Stat. § 506.120(1) in carrying out the violations. Additionally, a person convicted of a violation shall be punished by imprisonment and/or: (1) for a misdemeanor, not more than \$1,000 per individual nor \$5,000 per corporation or twice the amount of gain received as a result of the violation, whichever is greater; or (2) for a felony, not more than \$10,000 per individual nor \$100,000 per corporation, or twice the amount of gain received as a result of the violation, whichever is greater. Furthermore, the violator may be ordered to make restitution to the victims suffering a monetary loss and to the insurance division for the cost of the investigation. The amount of restitution shall equal the monetary value of the actual loss or the amount of gain received as a result of the violation, whichever is greater.

MINNESOTA

What laws in Minnesota prohibit insurance fraud and abuse?

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 involve someone who: (1) knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval; (2) knowingly makes or uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim; (3) knowingly conspires to commit a violation of clause (1), (2), (4), (5), (6), or (7); (4) has possession, custody, or control of property or money used, or to be used, by the state or a political subdivision and knowingly delivers or causes to be delivered less than all of that money or property; (5) is authorized to make or deliver a document certifying receipt for money or property used, or to be used, by the state or a political subdivision and, intending

²⁵ Proposed legislation (H.B. 89) and (H.B. 126) would raise this threshold amount to one thousand five hundred dollars (\$1,500).

to defraud the state or a political subdivision, makes or delivers the receipt without completely knowing that the information on the receipt is true; (6) knowingly buys, or receives as a pledge of an obligation or debt, public property from an officer or employee of the state or a political subdivision who lawfully may not sell or pledge the property; or (7) knowingly makes or 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 state or a political subdivision, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the state or a political subdivision.

Minnesota's criminal code prohibits Medicaid fraud. Specifically, the code states that any person who, with intent to defraud, presents a claim for reimbursement, a cost report, or a rate application, relating to the payment of medical assistance funds pursuant to the Medicaid program, to the state agency, which is false in whole or in part, is guilty of an attempt to commit public funds and may be sentenced accordingly. Minn. Stat. § 609.466.

What are the Qui Tam Provisions and Whistleblower Protections?

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, contractors, or agents who are discharged, demoted, suspended, threatened, harassed, or otherwise discriminated against in terms of their employment, because they took lawful acts done in furtherance of an action under the MFCASA, or other efforts to stop one or more such violations. Such employees, contractors, and agents are entitled to reinstatement with the same seniority status that the employee, contractor, or agent would have had but for the discrimination, two times the amount of back pay, interest on the back pay, and compensation for any special damages sustained as a result, including litigation costs and reasonable attorney fees. However, a civil action may not be brought more than 3 years after the date when the retaliation occurred.

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.²⁶ 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.

Violations of the Minnesota criminal code prohibiting medical assistance fraud is punishable: (1) to imprisonment of not more than 20 years or a fine of not more than \$100,000 or both if the value of the property or services stolen is more than \$35,000; or (2) to imprisonment of not more than 10 years or a fine of not more than \$20,000, or both, if the value of the property or services stolen exceeds \$5,000; or (3) to imprisonment of not more than five years or a payment of a fine of not more than \$10,000, or both if the value of the property or services is less than \$5,000.

²⁶ Senate File No. 2774 proposes modifying civil monetary penalty amounts to match the amounts set forth in the federal False Claims Act.

NEBRASKA

What are the Nebraska False Medicaid Claims Act, the prohibition against public assistance fraud, and the Insurance Fraud 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. The purpose of the Nebraska Insurance Fraud Act (“NIFA”)(Neb. Rev. Stat. Ann. § 44-6601 *et seq.*) is to combat the problem of insurance fraud by facilitating the detection of insurance fraud, eliminating its occurrence through the development of fraud prevention programs, authorizing the imposition of civil penalties, authorizing restitution of fraudulently obtained insurance benefits, and reducing the amount of premium dollars used to pay fraudulent claims. Neb. Rev. Stat. Ann. § 44-6602.

Violations of the FMCA include: (1) knowingly presenting or causing to be presented 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 material²⁷ 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 delivering, or causing to be delivered, less than all of the money or property; (5) being 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, making or delivering the receipt knowing that the information on the receipt is not true; (6) knowingly buying or receiving 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 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 or knowingly concealing, avoiding, or decreasing an obligation to pay or transmit money or property to the state.

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.

Similarly, Nebraska’s Medicaid program rules state that the law is violated if any person, including vendors and providers of medical assistance and social services, who, by means of a willfully false statement or representation, or by impersonation or other device, obtains or attempts to obtain, or aids and abets any person to obtain or to attempt to obtain any payment to which such individual is not entitled or a larger payment than that to which he or she is entitled. Neb. Rev. Stat. § 68-1017(1).

A person or entity violates NFIA and commits a fraudulent insurance act if he or she: (1) knowingly and with intent to defraud or deceive presents, causes to be presented, or prepares with knowledge or belief that it will be presented to or by an insurer, or any agent of an insurer, any statement as part of, or in denial of a claim for payment or other benefit from an insurer or pursuant to an insurance policy knowing that the statement contains any false, incomplete, or misleading information concerning any fact or thing material to a claim; (2) assists, abets, solicits, or conspires with another to prepare or make any statement that is intended to be presented to or by an insurer or person in connection with or in support of any claim for payment or other benefit from an insurer or pursuant to an insurance policy knowing that the statement contains any false, incomplete, or misleading information concerning any fact or thing material to the claim; (3) makes any false or fraudulent representations as to the death or disability of a policy holder or certificate holder or a covered person in any statement or certificate for the purpose of fraudulently obtaining money or benefit from an insurer;

²⁷ “Material,” is defined as “having a natural tendency to influence or be capable of influencing the payment or receipt of money or property.”

(4) knowingly and willfully transacts any contract, agreement, or instrument in violation of the Act; (5) willfully embezzles, abstracts, purloins, misappropriates, or converts money, funds, premiums, credits, or other property of an insurer or person engaged in the business of insurance; and (6) knowingly and with intent to defraud or deceive makes any false entry of a material fact in or pertaining to any document or statement filed with or required by the department. Neb. Rev. Stat. § 44-604.

What are the Qui Tam Provisions and Whistleblower Protections?

The FMCA, the Medicaid program rules, and NIFA *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.

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 \$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.

Under the Medicaid program rule, if the aggregate value of all funds or other benefits obtained or attempted to be obtained from the Medicaid program is: (1) less than \$500, the violator shall be guilty of a Class IV misdemeanor; (2) between \$500-\$1,500, the violator shall be guilty of a Class III misdemeanor; or (3) more than \$1,500, the person shall be guilty of a Class IV felony. Neb. Rev. Stat. § 68-1017(2).

Violators of the NIFA are subject to a civil penalty of no more than \$5,000 for the first violation, \$10,000 for the second violation, and \$15,000 for each subsequent violation and may be assessed costs and expenses occurred in any investigation or other action arising out of a violation of the Act. An action under NIFA is exclusive and the violator may not be prosecuted under the criminal statute. Neb. Rev. Stat. § 44-6607.

NEVADA

What are the Nevada False Claims Act and the prohibition against Medicaid fraudulent acts?

Nevada's False Claims Act (Nev. Rev. Stat § 357.010 *et seq.*) states that a person violates the law and is liable to the state when, with or without specific intent to defraud he: knowingly presents or causes to be presented a false or fraudulent claim or approval; knowingly makes or uses or causes to be made or used a false record or statement that is material to a false or fraudulent claim; knowingly makes or uses or causes to be made or used a false record or statement that is material to an obligation to pay or transmit money or property to the state; is a beneficiary of an inadvertent submission of a false claim and, after discovering the falsity of the claim, fails to disclose the falsity to the state within a reasonable time; or conspires to commit any of the aforementioned acts. Nev. Rev. Stat. § 357.040(1)(a),(b),(f),(h), and (i). Nevada's Medicaid statutes specifically prohibit the following violations against the program: making or causing a claim to be made, making or causing to be made a statement or representation for use in obtaining or seeking to obtain authorization to provide specific goods or services, and making or causing to be made a statement in representation for use in qualifying as a provider, while knowing the statement or representation to be false, in whole or in part, by commission or omission. Nev. Rev. Stat. § 422.540(1). Additionally, each application or report submitted to participate as a provider, each report stating income or expense upon which rates of payment are or may be based, and each invoice for payment of goods or services provided to a recipient must contain a statement that all matters stated therein are true and accurate and must be signed by a provider or a person authorized to act for the provider. It is a violation of the Medicaid statutes to sign, submit, or cause to be signed or submitted one of those statements knowing that the application, report, or invoice contains information which is false, in whole or in part, by commission or omission. Nev. Rev. Stat. § 422.550(1)-(2). An action for filing false claims or retaining an overpayment must be commenced within 4 years of the date on which the aggrieved party discovers the facts constituting the violation. Nev. Rev. Stat. Ann. § 422.590.

Nevada's Medicaid program rules also prohibit fraudulent acts. A person, with the intent to defraud, commits a violation if the person: (1) makes a claim or causes it to be made, knowing the claim to be false; (2) makes or causes to be made a

statement or representation for use in obtaining or seeking to obtain authorization to provide specific goods or services, knowing the statement or representation to be false; (3) makes or causes to be made a statement or representation for use by another in obtaining goods or services pursuant to the plan, knowing the statement or representation to be false in whole or in part, by commission or omission. Nev. Rev. Stat. Ann. § 422.540(1).

What are the Qui Tam Provisions and Whistleblower Protections?

Nevada laws contain provisions permitting *qui tam* relators to bring forth a suit on the government's behalf. If the Attorney General intervenes at the outset of the action, the *qui tam* relator is entitled to not less than 15 percent or more than 25 percent of any recovery, according to the extent of his contribution to the conduct of the action. Nev. Rev. Stat. § 357.210(1). If the Attorney General does not intervene, the relator is entitled to receive not less than 25 percent or more than 30 percent of any recovery. Nev. Rev. Stat. § 357.210(2). Regardless of whether the Attorney General intervenes, if the court finds that the *qui tam* relator planned or initiated the violation upon which the action is based, the court may reduce the recovery to which he would otherwise be entitled. If the *qui tam* relator is convicted of criminal conduct arising from his role in the violation, he must be dismissed from the civil action and may not receive any share of the recovery. Nev. Rev. Stat. § 357.210(3). An action by a *qui tam* relator may not be commenced more than 3 years after the date on which the Attorney General or a designee discovers, or reasonably should have discovered, the fraudulent activity, but in no event more than 10 years after the fraudulent activity occurred; or more than 6 years after the fraudulent activity occurred, whichever occurs later. Nev. Rev. Stat. § 357.170.

Nevada's false claims act protects employees, contractors, or agents who are discharged, demoted, suspended, threatened, harassed, or discriminated against in the terms and conditions of employment as a result of any lawful act by the individual in furtherance of a *qui tam* action or any other effort to stop a violation of the false claims act, the individual is entitled to all relief necessary to make him whole, including, without limitation, reinstatement with the same seniority as if the discharge, demotion, suspension, threat, harassment, or discrimination had not occurred. Alternatively, damages in lieu of reinstatement may be appropriate, including twice the amount of lost compensation, interest on the lost compensation, any special damage sustained as a result of the discharge, demotion, suspension, threat, harassment, or discrimination, and punitive damages, as appropriate. The employee, contractor, or agent must file a civil action no more than 3 years after the date on which the discharge, demotion, suspension, threat, harassment, or discrimination occurred. Nev. Rev. Stat. § 357.250.

What are the penalties?

For violations of the Nevada False Claims Act, a person is liable for three times the amount of damages sustained by the State because of the act of the person, the costs of a civil action brought to recover the damages, and a civil penalty of not less than \$5,500 or more than \$11,000. Nev. Rev. Stat. § 357.040(2). However, if the person against whom the judgment is entered furnished all information known to the person concerning the act within 30 days after becoming aware of the information to the Attorney General or his designee, fully cooperated with any investigation of the act by the state, and at the time the information was furnished, no criminal prosecution or civil or administrative proceeding had commenced with respect to the violation and the person had no knowledge of the existence of any investigation with respect to the act, the court may give judgment for not less than twice or more than three times the amount of damages sustained and no civil penalty. Nev. Rev. Stat. § 357.050.

For violations of the Nevada Medicaid False Claims Act, a person will be charged with a Category D felony if the amount of the claim or the value of the goods or services obtained or sought to be obtained was greater than or equal to \$650. If the amount of the claim or the value of the goods or services obtained or sought to be obtained was less than \$650, the violator will be charged with a misdemeanor. Furthermore, amounts involved in separate violations of this section committed pursuant to a scheme or continuing course of conduct may be aggregated in determining the punishment. In addition to any other penalty for a violation of the commission of an offense described in subsection 1, the court shall order the person to pay restitution. Nev. Rev. Stat. Ann. § 422.540(2) and (3). A person who has signed or submitted a statement submitted to the agency knowing that any part of it is false is guilty of perjury, a category D felony.

A Medicaid provider who receives payment to which he is not entitled to is liable for an amount equal to three times the amount unlawfully obtained; not less than \$5,000 for each false claim, statement, or representation; an amount equal to

three times the total of the reasonable expenses incurred by the state in pursuing an action against the violator; and payment of interest on the amount of the excess payment. A Medicaid provider who unknowingly accepts a payment in excess of the amount to which the provider is entitled is liable for the repayment of the excess amount. Nev. Rev. Stat. Ann. § 422.580(1) and (3). Additionally, if Medicaid provider or his agent or employee, with the intent to defraud, furnishes medical care upon presentation of a Medicaid card that the provider knows was obtained or retained fraudulently or is forged, expired, or revoked, the provider or his agent or employee is guilty of a category D felony, which is punishable by imprisonment in the state prison for no less than 1 year and no more than 4 years. Additionally, the court may impose a fine of not more than \$5,000 and require the convicted person to pay restitution. Nev. Rev. Stat. Ann. § 422.369.

A person who intentionally fails to maintain records as necessary to disclose fully the nature of the goods or services for which a claim was submitted within 5 years after the date payment was received is guilty of a category D felony, which is punishable by imprisonment in the state prison for a minimum term of not less than 1 year and a maximum term of not more than 4 years. In addition, the court may impose a fine of not more than \$5,000. Nev. Rev. Stat. Ann. § 422.570.

Violators of the Medicaid program rules are guilty of a category D felony if the amount of the claim or value of the goods or services obtained or sought to be obtained was greater than or equal to \$650, or a misdemeanor if the claim or value was less than \$650. Violators must also pay restitution. Nev. Rev. Stat. Ann. § 422.540(2).²⁸

NEW MEXICO

What are the New Mexico Medicaid False Claims Act, Fraud Against Taxpayers Act, & Medicaid Fraud Act?

New Mexico has several applicable statutes to fight false claims. First, is the Medicaid False Claims Act (“MFCA”) (N.M. Stat. Ann. §§ 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, 2004.²⁹ Second, is the Fraud Against Taxpayers Act (“FATA”) (N.M. Stat. Ann. §§ 44-9-1 to 44-9-14), 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, 2007.³⁰ The statutes are very similar, but the main difference is that the FATA is not exclusive to the Medicaid

²⁸ S.B. 60, introduced on February 4, 2019, proposes to: add that the statutes of limitations generally applicable to civil actions, misdemeanors, felonies, and crimes committed in a secret manner do not apply to civil or criminal actions for Medicaid fraud; increase the criminal penalties for Medicaid fraud if the amount of the claim or value of goods or services at issue exceeds \$650; authorize the Attorney General to use any documents, records, or materials produced pursuant to a subpoena for prosecuting Medicaid fraud to be used in a criminal action.

²⁹ Proposed legislation (S.B. 519) would: entirely revise the definitions section under § 24-14-3, including defining additional words; entirely revise § 27-14-4; which defines liability under the act; add that the attorney general is authorized to take many of the actions that the department takes; add the relator as a party to whom the department and attorney general may disclose documentary material in possession of a state agency under § 27-14-5; modify the language under § 27-14-7 to utilize the terms “qui tam” and “relator” as appropriate; modify § 27-14-7 to address the role of the attorney general in a civil action; add that the attorney general is authorized to prosecute a civil action for a violation of the Medicaid False Claims Act; and add that once a qui tam action is brought, no person other than the government may intervene or bring a related action based on the facts underlying the pending action.

³⁰ Proposed legislation (S.B. 519) would: modify and add definitions under § 44-9-1, including “document,” “qui tam action,” and “relator”; add that investigation by the attorney general is at his/her discretion; assigns certain responsibilities to the attorney general where they were previously assigned generally to “the state or political subdivision” in § 44-9-5; entirely revise the rights of qui tam parties under § 44-9-6; further define how proceeds and penalties collected by the state or political subdivision shall be deposited under § 44-9-7; modify the circumstances under which a court may dismiss a qui tam action if the elements of the alleged false or fraudulent claim have been publicly disclosed from “news media or in a publicly disseminated government report at the time the complaint is filed” to “(1) in an a state criminal, civil, or administrative proceeding to which the state or political subdivision or agent of either was a party; (2) in a legislative or other state report, audit or investigation; or (3) in the news media”; add a civil investigative demand to § 44-9-12; and modify the legislation to utilize the appropriate terminology for a qui tam action throughout.

program like the MFCA. Finally, New Mexico maintains a general Medicaid Fraud Act (“MFA”) (N.M.S.A. §30-44-7)³¹ that may apply in scenarios involving false claims. The MFA became effective on April 8, 1997.

Violations of the MFCA include: (1) presenting, or causing to be presented, to the state a claim for payment under the Medicaid program knowing that such claim is false or fraudulent; (2) presenting, or causing to be presented, 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, using, or causing to be made 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, using, or causing to be made or used 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.³²

Violations of the FATA include: (1) knowingly presenting or causing to be presented to an employee, officer, or agent of the state or a political subdivision or to a contractor, grantee, or other recipient of state or political subdivision funds a false or fraudulent claim for payment or approval; (2) knowingly making or using, or causing to be made or used, a false, misleading, or fraudulent record or statement to obtain or support the approval of or the payment on a false or fraudulent claim; (3) conspiring to defraud the state or a political subdivision 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 an obligation to pay or transmit money or property to the state or a political subdivision; (5) when in possession, custody, or control of property or money used or to be used by the state or a political subdivision, knowingly delivering or causing to be delivered less property or money than the amount indicated on a certificate or receipt; (6) when authorized to make or deliver a document certifying receipt of property used or to be used by the state or a political subdivision, knowingly making or delivering a receipt that falsely represents a material characteristic of the property; (7) knowingly buying, or receiving as a pledge of an obligation or debt, public property from any person that may not lawfully sell or pledge the property; (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 or transmit money or property to the state or a political subdivision; or (9) as a beneficiary of an inadvertent submission of a false claim and having subsequently discovered the falsity of the claim, failing to disclose the false claim to the state or political subdivision within a reasonable time after discovery.³³

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

³¹ Proposed legislation (S.B. 217) would add that without evidence of a culpable mental state, neither of the following shall constitute Medicaid fraud: (1) a failure to comply with service definitions or guidelines issued by the department or a Medicaid managed care organization or (2) a breach of contractual terms or provisions. S.B. 217 passed both House and Senate, but Governor used pocket veto 1/29/2017.

³² Proposed legislation (H.B. 201) would substantively amend several portions of the MFCA, including revising the definitions, most all violations would now require an intent of “knowingly,” and would change the language provided for qui tam actions and qui tam party rights (including an award to relators). H.B. 201 postponed indefinitely 2/9/2016.

³³ Proposed legislation (H.B. 201) would amend portions of the FATA regarding qui tam actions, relators, and awards. H.B. 201 postponed indefinitely 2/9/2016.

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.³⁴

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 30% 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. However, under the FATA, if the attorney general or political subdivision determines and certifies in writing that the *qui tam* plaintiff provided a significant contribution in advancing the case, then the *qui tam* plaintiff shall receive the share of proceeds described above. Regardless of whether the government proceeds with the action, if the court finds that the action was brought by a person who planned and initiated the violation upon which the action was brought, then the court may, to the extent the court considers appropriate, reduce the share of the proceeds that the *qui tam* relator would otherwise receive, taking into account the role of the person in advancing the case to litigation and any relevant circumstances pertaining to the violation. However, if the *qui tam* relator is convicted of criminal conduct arising from the person's role in the violation of the MFCA, that person shall be dismissed from the action and not receive any share of the proceeds of the action.

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. Under the MFCA, violators are liable for treble damages and civil recoveries.

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

³⁴ Proposed legislation (S.1227) would amend the definition of "Medicaid Fraud" to exclude certain activities, unless accompanied by evidence of culpable mental state, including: (1) a failure to comply with service definitions or guidelines issued by a department or a Medicaid managed care organization; or (2) a breach of contractual terms or provisions.

be subject to both civil and criminal penalties and sentencing procedures.³⁵ 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 \$10,000 for each false or fraudulent claim submitted or representation made for providing treatment, services, or goods; and (4) payment of legal fees, 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 (1) or (3) is guilty of a fourth degree felony. Someone who commits Medicaid fraud in violation of subsection (2) or (4) when the value of the benefit, treatment, services, or goods improperly provided is: (1) not more than \$100, he or she is guilty of a petty misdemeanor; (2) between \$100 and \$250, he or she is guilty of a misdemeanor; (3) between \$250 and \$2,500, he or she is guilty of a fourth degree felony; (4) between \$2,500 and \$20,000, he or she is guilty of a third degree felony; and (5) more than \$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 \$50,000 for each misdemeanor and not more than \$250,000 for each felony.

NORTH DAKOTA

What are the North Dakota Medicaid fraud statute, Medicaid Provider Integrity Laws and Regulations, and insurance fraud statute?

North Dakota established a Medicaid Fraud Control Unit effective August 1, 2019. N.D. Cent. Code § 50-24.8-01 *et seq.* This statute prohibits: (1) knowingly presenting or causing to be presented 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) conspiring to commit a violation of this section of the code; (4) having possession, custody, or control of public property or money used or to be used by the state and knowingly delivering or causing to be delivered less than all of that money or property; (5) being authorized to make or deliver a document certifying receipt of property used or to be used by the state and, with the intent to defraud the state, making or delivering a receipt without completely knowing the information on the receipt is true; and (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 or knowingly concealing or knowingly and improperly avoiding or decreasing an obligation to pay or transmit money or property to the state. N.D. Cent. Code § 50-24.8-02(1). Additionally, it establishes that knowingly presenting for allowance, for payment, or for the purpose of concealing, avoiding, or decreasing an obligation to pay a false or fraudulent medical assistance a claim, bill, account, voucher, or writing to a public agency, public servant, or contractor authorized to allow or pay medical assistance claims or conspiring to do so.

North Dakota's insurance fraud statute (N.D. Cent. Code § 26.1-02.1-01 *et seq.*) prohibits committing a fraudulent insurance act and knowingly or intentionally interfering with the enforcement of the statute. N.D. Cent. Code § 26.1-02.1-02.1(1)-(2). A fraudulent insurance act is defined as presenting, causing to be presented, or preparing with the knowledge or belief that it will be presented to or by an insurer, reinsurer, insurance producer, or any agent thereof, false or misleading information as part of, in support of, or concerning a fact material to one or more of the following: a claim for payment or benefit pursuant to an insurance policy or reinsurance contract, payments made in accordance with the terms of an insurance policy or reinsurance contract; theft by deception or otherwise, or embezzlement, abstracting, purloining, or conversion of moneys, funds, premiums, credits, or other property of an insurer, reinsurer, or person engaged in the business of insurance; and attempting to commit, aiding, or abetting in the commission of, or conspiring to

³⁵ Proposed legislation (H.B. 85) would give the Medicaid fraud unit the authority to review complaints alleging misappropriation of funds of residents of board and care facilities, regardless of whether payment is made under Medicaid. H.B. 85 was passed and vetoed by Governor 1/30/2017.

commit the actions specified in the statute. N.D. Cent. Code § 26.1-01.1-01(5). Additionally, 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 75-02-05-07; Remedies N.D. Cent. Code §§ 32-03-01 to 32-03-58; 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 apply to Medicaid reimbursement and prohibit the following: (1) presenting a false or fraudulent claim; (2) submitting or causing to be submitted false information to obtain greater compensation than to which the provider is entitled; (3) submitting false information for the purpose of meeting prior authorization requirements; (4) submitting false, intentionally misleading, or fraudulent information for the purpose of meeting prior authorization or level of care requirements; (5) submitting false, intentionally misleading, or fraudulent information to obtain provider status; (6) submitting a false, intentionally misleading, or fraudulent certification or statement, whether the certification or statement is explicit or implied, to the department or department's representative or to any other publicly or privately funded healthcare program; (7) failing to comply with the terms of the Medicaid provider agreement; (8) failing to comply and maintain compliance with all state and federal regulations applicable to the provider's profession, business, or enterprise; and (9) defrauding any health care benefit program. N.D. Admin. Code § 75-02-05-05.

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.

Employees, contractors, or agents are entitled to all relief necessary to make them whole if they are discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment because of lawful acts done by the employee, contractor, agent, or associated others in furtherance of an action under the statute or an effort to stop a violation of the statute. Relief includes reinstatement with the same seniority status that the individual would have had but for the discrimination, 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. A civil action may not be brought more than three years after the date the retaliation occurred. N.D. Cent. Code. § 50-24.8-08.

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 within 180 days after the alleged violation, completion of proceedings under the department of labor and human rights, or completion of any grievance procedure available to the employee under the employee's collective bargaining agreement, employment contract, or any public employee statute, rule, or policy, whichever is later. The court may award reinstatement, back-pay, injunctive relief, reinstatement of fringe benefits or a combination of remedies. N.D. Cent. Code § 34-01-20.

What are the Penalties?

Under the Medicaid fraud statute, a civil action must be brought by the later of six years after the date on which the violation was committed or three years after the date facts material to the right of action are known or reasonably should have been known by the official of the state charged with responsibility to act in the circumstances, but no more than ten years after the date on which the violation was committed. N.D. Cent. Code § 50-24.8-03.

The Medicaid fraud statute contains both civil and criminal penalties. Civil penalties include \$1,000-\$10,000 per violation, treble damages, and costs of the investigation and litigation fees. The court may assess double damages if it finds that the person committing the act furnished the attorney general with all information known to that person about the prohibited act within 30 days after the date on which the person first obtained the information, the person fully cooperated with any investigation of the act by the attorney general, and at the time the person furnished the attorney general with information about the act, a criminal prosecution, civil action, or administrative action had not been commenced with

respect to the act and the person did not have actual knowledge of the existence of an investigation into the violation. If the total claim made or presented by a person is less than \$100,000, the civil penalty may not be more than fifteen percent of the total claim submitted. N.D. Cent. Code § 50-24.8-02. A person convicted of Medicaid fraud involving payments, benefits, kickbacks, bribes, rebates, remuneration, services, or claims not exceeding \$1,000 is guilty of a class A misdemeanor, or a class C felony if the value is between \$1,000-\$10,000 and part of a common scheme, or a class B felony if the value is between \$10,000-\$50,000, or a class A felony if the value is greater than \$50,000 and part of a common scheme. Additionally, a person convicted of a violation must be suspended from participation in the Medicaid program: (1) for at least a year for a first offense, or permanently; (2) for at least three years for a second offense, or permanently; or (3) permanently for a third offense. Lastly, a convicted person may not bill or collect from the recipient, the Medicaid program, or any other third-party payer for the services or items involved and must repay any payments or benefits obtained by any person for the services or items involved. N.D. Cent. Code § 24.8-11.

Penalties for violating the North Dakota insurance code include criminal penalties and restitution. If the value of any property or services retained is greater than \$50,000, it is a Class A felony; or a class B felony if the value of the act associated with the fraud or directly related to the fraud is greater than \$50,000; or a class B felony if the value of any property or services retained is between \$10,000-\$50,000; or a class C felony if the value of the act associated with the fraud or directly related to the fraud is between \$10,000-\$50,000; or a class C felony if the value of any property or services retained is between \$1,000-\$10,000; or a class A misdemeanor in all other cases. A prosecution for any felony offense must be commenced within three years after the date of the discovery of the fraud, and a prosecution for any misdemeanor or infraction must be commenced within two years after the date of discovery of the fraud. Additionally, if a practitioner is adjudicated guilty of a violation, the court must notify the appropriate licensing authority of the state of North Dakota of the adjudication, and the licensing authority shall hold an administrative hearing to consider the imposition of administrative sanctions against the practitioner. Additionally, a violator must be ordered to make restitution to the insurer or any other person for any financial loss sustained as a result of the violation. The extent and method of restitution shall be determined by the court. N.D. Cent. Code § 26.1-02.1-05.

Violations of the Medicaid Provider Integrity Laws and Regulations 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.

OHIO

What are the Ohio laws prohibiting false claims?

Ohio has a collection of laws that serve the purpose of preventing the commission of fraud (Ohio Rev. Code Ann. §§§§§ 2913.40 to 2913.401; 2921.47; 4113.52; 2307.65 and 5164.35).

The chief actions that violate the Medicaid fraud 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.

Additionally, providers are prohibited from: by deception, obtaining or attempting to obtain payments under the Medicaid program to which the provider is not entitled pursuant to the provider's provider agreement or the rules of the federal government or the Medicaid director relating to the program; willfully receiving payments to which the provider is not entitled; willfully receiving payments in a greater amount than that to which the provider is entitled; and falsifying any

report or document required by state or federal law, rule, or provider agreement relating to Medicaid payments. “Deception” is defined as acting with actual knowledge of the representation or information involved, acting in deliberate ignorance of the truth or falsity of the representation or information involved, deceiving another or causing another to be deceived by any false or misleading representation, or by any other conduct, act, or omission that creates, confirms, or perpetuates a false impression in another, including a false impression as to law, value, state of mind, or other objective or subjective fact. No proof of specific intent to defraud is required to show that a Medicaid provider has engaged in deception. Ohio Rev. Code Ann. § 5164.35(B)-(C).

Ohio’s insurance fraud statute prohibits any person, with purpose to defraud or knowing that the person is facilitating a fraud, from: (1) presenting to, or causing to be presented to, an insurer any written or oral statement that is part of, or in support of, an application for insurance, a claim for payment pursuant to a policy, or a claim for any other benefit pursuant to a policy, knowing that the statement, or any part of the statement, is false or deceptive; and (2) assisting, aiding, abetting, soliciting, procuring, or conspiring with another to prepare or make any written or oral statement that is intended to be presented to an insurer as part of, or in support of, an application for insurance, a claim for payment pursuant to a policy, or a claim for any other benefit pursuant to a policy, knowing that the statement, or any part of the statement, is false or deceptive. Ohio Rev. Code Ann. § 2913.47(B).

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. § 4113.53.³⁶

What are the Penalties?

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

³⁶ H.B. 238 proposes to clarify the process for reporting violations and expanding protections for whistleblowers, including extending the statute of limitations for a retaliation action to one year.

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.

Providers that engage in deception shall be liable for interest on the amount of excess payments at the maximum interest rate allowable for real estate mortgages on the date the payment was made to the provider for the period from the date upon which payment was made to the date upon which repayment was made to the state, treble damages, penalties of \$5,000-\$10,000 per deceptive claim or falsification, and all reasonable expenses the court determines were incurred by the state in enforcement. Additionally, upon conviction of or entry of a judgment in either a criminal or civil action against a Medicaid provider or its owner, officer, authorized agent, associate, manager, or employee shall terminate the provider's provider agreement and stop payment to the provider for Medicaid services rendered from the date of conviction or entry of judgment. However, the provider agreement and payment shall not be terminated if the Medicaid provider or owner can demonstrate that the provider or owner did not directly or indirectly sanction the action of its authorized agent, associate, manager, or employee that resulted in the conviction or entry of a judgment. The attorney general may commence a proceeding under this section at any time within six years after the conduct in violation terminates. Ohio Rev. Code Ann. § 5164.35.

The Ohio insurance fraud statute contains criminal penalties. If the amount of the claim that is false or deceptive is: less than \$1,000, it is a misdemeanor of the first degree; between \$1,000-\$7,500, it is a felony of the fifth degree; between \$7,500-\$150,000, it is a felony of the fourth degree; and greater than \$150,000, it is a felony of the third degree. Ohio Rev. Stat. Ann. § 2913.47(C).

OREGON

What is the Oregon False Claims Act & 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. §§ 180.750 to 180.785. The OFCA became effective on January 10, 2010. Also, Oregon has a False Claims for Health Care Payments Act ("OFCHCP") (Or. Rev. Stat. Ann §§ 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. Or. Rev. Stat. Ann. § 180.755(2).

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. Or. Rev. Stat. Ann. § 165.692.

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. Or. Rev. Stat. Ann. § 180.760.

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. Or. Rev. Stat. Ann. § 165.698.

PENNSYLVANIA

What are the Pennsylvania Fraud and Abuse Control Act, Pennsylvania Whistleblower Law, and law against insurance fraud?

Pennsylvania maintains a Fraud and Abuse Control Act (“PFAC”) (62 Pa. Stat. and Cons. Stat. Ann. § 1401 *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 or referring a recipient to another provider by referral, order, or prescription, 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. 62 Pa. Stat. and Cons. Stat. Ann. § 1407.

Additionally, a person violates 18 Pa. Con. Stat. § 4117 if he: (1) knowingly and with the intent to defraud any insurer or self-insured, presents or causes to be presented to any insurer or self-insured any statement forming a part of, or in support of, a claim that contains any false, incomplete, or misleading information concerning any fact or thing material to the claim; (2) knowingly and with the intent to defraud any insurer or self-insured in connection with, or in support of, a claim that contains any false, incomplete, or missing information concerning any fact or thing material to the claim; (3) knowingly benefitting, directly or indirectly, from the proceeds derived from a violation due to the assistance, conspiracy, or urging of any person; and (4) is the owner, administrator, or employee of any health care facility and knowingly allows the use of such facility by any person in furtherance of a scheme or conspiracy to violate any of the provisions on insurance fraud.

What are the Qui Tam Provisions and Whistleblower Protections?

Neither the PFAC nor the insurance fraud section contain *qui tam* provisions. Separate from the PFAC, Pennsylvania has a Pennsylvania Whistleblower Law ("PWL") (43 Pa. Stat. and Cons. Stat. Ann. §§ 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. Further, after making a report to the appropriate authorities, the authority is prohibited from disclosing the identity of the whistleblower without his/her consent, except in specified circumstances.

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 \$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 \$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, including a fine of not more than \$10,000.

An insurer damaged as a result of a violation of the insurance fraud section may sue to recover compensatory damages, which may include reasonable investigation expenses, costs of suit, and attorney's fees, as well as treble damages if the court determines that the defendant has engaged in a pattern of insurance fraud violations. 18 Pa. Con. Stat. § 4117(e). The court may also sentence a violator to make restitution. 18 Pa. Con. Stat. § 4117(g). Additionally, a violator shall be subject to civil penalties of not more than \$5,000 for the first violation, \$10,000 for the second violation, and \$15,000 for each subsequent violation. The court may also award court costs and reasonable attorney fees to the prosecuting authority. 18 Pa. Con. Stat. § 4117(j).

TENNESSEE

What are the Tennessee Medicaid False Claims Act, Tennessee False Claims Act, TennCare Fraud and Abuse Reform Act, Tennessee Fraudulent Insurance Act, and Tennessee Unlawful Insurance Act?

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. Additionally, Tennessee maintains a TennCare Fraud and Abuse Reform Act of 2004 ("TFAR") (Tenn. Code Ann. § 71-5-2501 *et seq.*) which aims at preventing fraud and abuse of the state Medicaid program, called TennCare. Tennessee also has a Fraudulent Insurance Act (Tenn. Code Ann. § 56-53-102) and an Unlawful Insurance Act (Tenn. Code Ann. § 56-53-103).

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. Tenn. Code Ann. § 71-5-2601.

The TFIA makes the following a criminal violation: knowingly and with intent to defraud and with the purpose of depriving another of property or for pecuniary gain, commits, participates in or aids, abets, or conspires to commit or solicits another person to commit, or intentionally permits its employees or its agents to present, cause to be presented, or prepare with knowledge or belief that it will be presented, by or on behalf of an insured, claimant, or applicant to an insurer, insurance professional, or premium finance company in connection with an insurance transaction or premium finance transaction, any information that contains false representations as to any material fact, or that withholds or conceals a material fact concerning a claim for payment or benefit pursuant to any insurance policy or payments made in

accordance with the terms of any insurance policy. The TFIA also prohibits diverting, misappropriating, converting, or embezzling the funds of an insurer, an insured, claimant, or applicant for insurance in connection with an insurance transaction. Tenn. Code Ann. § 56-53-102(a)(1)-(2).

The TUIA makes the following a civil violation: committing, participating in, or aiding, abetting, or conspiring to commit, or soliciting another person to commit, or permitting its employees or agents to commit the following with an intent to induce reliance: presenting, causing to be presented, or preparing with knowledge and belief it will be presented, by or on behalf of an insured, claimant, or applicant to an insurer, insurance professional, or a premium finance company in connection with an insurance transaction or premium finance transaction, any information that the person knows to contain false representations, or representations the falsity of which the person has recklessly disregarded, as to any material fact, or that withholds or conceals a material fact concerning a claim for payment or benefit pursuant to any insurance policy and payments made in accordance with the terms of any insurance policy. Tenn. Code Ann. § 56-53-103(a)(1).

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. An individual who litigates a case on his or her own without the government can receive a higher recovery.

Both the TFCA and TMFCA 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, including litigation costs and reasonable attorneys’ fees. Under the TFCA, the employer may also be liable for punitive damages.

TFAR, TFIA, and TUIA do not contain *qui tam* provisions nor whistleblower protections.

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. Tenn. Code Ann. § 4-18-103(a). Penalties of \$5,000 to \$25,000 per claim plus treble damages may be imposed for TMFCA violations. Tenn. Code Ann. § 71-5-182(a)(1)(A). The courts can waive penalties and reduce damages for violations if the false claims are voluntarily disclosed. Additionally, upon written request of the attorney general and reporter, the bureau of TennCare may bring an action as an administrative proceeding on behalf of the state for recovery against any person specified by the attorney general and reporter. The amount of damages that the state may seek in such administrative proceeding shall not exceed \$25,000. This limit does not apply to civil penalties or costs that the state is eligible to recover related to double or treble damages. The administrative penalty for each violation in such administrative proceeding shall be between \$1,000-\$5,000. Tenn. Code Ann. § 71-5-183(h).

An individual who violates a subsection of the TFAR is guilty of either (i) a Class B felony when the value of the services unlawfully obtained is between \$60,000 and \$250,000; (ii) a Class C felony if the value of the services unlawfully obtained is between \$10,000 and \$60,000; or (iii) a Class D felony when the value of services unlawfully obtained is between \$1,000 and \$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 8 and 16 years’ imprisonment and a fine not to exceed \$50,000; (b) for

a Class C felony, between 3 and 15 years' imprisonment and a fine not to exceed \$10,000; (c) for a Class D felony, between 2 and 12 years' imprisonment and a fine not to exceed \$5,000. Tenn. Code Ann. § 71-5-2601.

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 years after the commission of the offense. Tenn. Code Ann. § 71-5-2601.

Violations of the TFIA are punishable as theft. Tenn. Code Ann. § 39-14-133. Additionally, the violator will be ordered to make restitution, which may be imposed in addition to a fine and, if ordered, any other penalty, but may not be ordered in lieu of a fine. The court determines the extent and method of the restitution. Tenn. Code Ann. § 56-53-105. If the violator is a practitioner, the court or prosecutor shall notify the appropriate licensing authority for disciplinary action. Tenn. Code Ann. § 56-53-106. Individuals injured by violations under TFIA may receive restitution, reasonable attorney's fees, related legal expenses, all other economic damages directly resulting from the violation, reasonable investigative fees, and a penalty of \$100-\$10,000. Tenn. Code Ann. § 56-53-107(b). If the injured party is able to demonstrate that the violation was part of a pattern or practice of such violations by clear and convincing evidence, the injured party shall be entitled to treble damages. This action must be brought within three years of the violation. The state is entitled to a third of the damages awarded. Tenn. Code Ann. § 56-53-107(c).

Individuals injured by violations under TUIA may receive restitution, reasonable attorneys' fees, and legal expenses from the violator. Tenn. Code Ann. § 56-53-107(a).

Actions under TFIA and TUIA must be brought within five years of the commission of the acts constituting the violation, or within five years of the time the plaintiff discovered, or with reasonable diligence could have discovered, the acts, whichever is later. Tenn. Code Ann. § 56-53-107(e).

TEXAS

What are the Texas Medicaid Fraud Prevention Act and the Texas Medicaid program rules prohibiting fraud?

The Texas Medicaid Fraud Prevention Act ("TMFPA")(Tex. Hum. Res. Code §§ 36.001 *et seq.*) 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, 1995.³⁷

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 individuals with an intellectual disability; an assisted living facility; or a home health agency;

³⁷ Proposed amendment (H.B. 2898) would modify the composition of "licensing authority" and licensing authorities of multiple professional groups under § 36.132(a)(2).

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. Tex. Hum. Res. Code § 36.002.

The Texas Medicaid program rules also prohibit presenting or causing to be presented to the Texas Health and Human Services Commission a claim that contains a statement or representation the person knows or should know to be false and failing to maintain documentation to support a claim for payment in accordance with Medicaid requirements or policy. Tex. Hum. Res. Code § 32.039(b)(1) and (3).

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. Tex. Hum. Res. Code § 36.101. 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. Tex. Hum. Res. Code § 36.102. If the state proceeds with an action, the relator is entitled to 15-25% of the proceeds of the action. If the state does not proceed, the relator is entitled to 25-30% of the proceeds of the action. However, if the court finds that the action is based primarily on information for which the relator is not the original source, the court may award the amount it considers appropriate, but not more than 10% of the proceeds of the action. Tex. Hum. Res. Code § 36.110. A *qui tam* relator must bring an action within six years of the unlawful act or within three years from the date the state knows or reasonably should have known facts material to the unlawful act, whichever is later, regardless of whether the unlawful act occurred more than six years before the date the lawsuit was filed, but in no event more than ten years after the unlawful act. Tex. Hum. Res. Code § 36.104(b).

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). Tex. Hum. Res. Code § 36.115.

The Texas Medicaid program rules do not include *qui tam* provisions or whistleblower protections.

What are the Penalties?

Violators of the TMFPA are subject to civil penalties ranging \$5,500 to \$11,000 for each violation unless the violation results in injuries to elderly, disabled, or persons under the age of 18, in which case the penalties range from \$5,500 to \$15,000 per violation. Tex. Hum. Res. Code § 36.052. 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. Tex. Hum. Res. Code § 36.052.

Additionally, the Texas Health and Human Services Commission will suspend or revoke a violator's provider agreement and permit, license, or certification. Violators may not provider or arrange to provide health care services under the Medicaid program or supply or sell, directly or indirectly, a product to or under the Medicaid program for a period of at least 10 years. Tex. Hum. Res. Code § 36.005. The attorney general may recover fees, expenses, and costs reasonably incurred in obtaining injunctive relief or civil remedies or in conducting investigations, including court costs, reasonable attorney's fees, witness fees, and deposition fees. Tex. Hum. Res. Code § 36.007.

Under the Texas Medicaid program rules, a violator must pay restitution plus interest, an administrative penalty not to exceed double damages, and a penalty of \$10,000 per violation, unless the violation results in injury to an elderly person, a person with a disability, or a person younger than 18 years of age, in which case the penalty is \$5,000-\$15,000 per violation. Tex. Hum. Res. Code § 32.039(c).

WASHINGTON

What are the Washington Health Care False Claims Act, Medicaid Fraud False Claims Act, and Medicaid prohibitions on fraudulent medical assistance practices?

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. Wash. Rev. Code Ann. §§ 48.80.010 to 48.80.900. The Washington Medicaid Fraud False Claims Act ("WMFFCA") (Wash. Rev. Code Ann. § 74.66.005 *et seq.*)³⁸ provides similar penalties and deterrents aimed specifically at false Medicaid claims. Additionally, the Washington Medicaid program rules prohibit fraudulent medical assistance practices. Wash. Rev. Code Ann. § 74.09.210.

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. Wash. Rev. Code Ann. § 40.80.030.

³⁸ Effective 7/1/2018, (H.B. 1388) changes the designation of the state behavioral health authority from the department of social and health services to the health care authority and transferring the related powers, functions, and duties to the health care authority and the department of health.

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. Wash. Rev. Code Ann. § 74.66.020(1).

The Washington Medicaid program rules add an additional layer of deterrence. The prohibition against fraudulent practices states that no person, firm, corporation, partnership, association, agency, institution or other legal entity shall obtain or attempt to obtain benefits or payments from the Medicaid program in an amount greater than that to which he or it is entitled by means of: (1) a willful false statement; (2) by willful misrepresentation, or by concealment of any material facts; or (3) by other fraudulent scheme or device, including, but not limited to: (a) billing for services, drugs, supplies, or equipment that were unfurnished, of lower quality, or a substitution or misrepresentation of items billed; or (b) repeatedly billing for purportedly covered items, which were not in fact covered. Wash. Rev. Code Ann. § 74.09.210(1). The prohibition against fraudulent statements states that any person, including any corporation, that (1) knowingly makes or causes to be made any false statement or representation of a material fact in any application for any payment under any public assistance medical program or at any time knowingly makes or causes to be made any false statement or representation of a material fact for use in determining rights to such payment, or (2) knowingly falsifies, conceals, or covers up by any trick, scheme, or device a material fact in connection with such application or payment, or (3) having knowledge of the occurrence of any event affecting either (a) the initial or continued right to any payment, or (b) the initial or continued right to any such payment of any other individual on whose behalf he or she has applied for or is receiving such payment, conceals or fails to disclose such event with an intent fraudulently to secure such payment either in a greater amount or quality than is due or when no such payment is authorized is guilty of a criminal offense. Wash. Rev. Code Ann. § 74.09.230. It is also a violation of the rules for providers to fill out any application, statement, or form that contains or is verified by a written statement that it is made under the penalties of perjury with false or misleading information. Wash. Rev. Code Ann. § 74.09.280.

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. Wash. Rev. Code Ann. § 74.66.050. If the attorney general proceeds with the *qui tam* action, the relator will receive 15-25% of the proceeds of the action or settlement of the claim. If the attorney general does not proceed with the *qui tam* action, the relator will receive 25-30% of the proceeds of the action or settlement. However, if the court finds that the action is based primarily on information for which the relator is not the original source, the court may award an amount it deems appropriate, but in no case more than 10% of the proceeds. The relator must also receive an amount for reasonable expenses necessarily incurred, plus reasonable attorneys' fees and costs. Wash. Rev. Code Ann. § 74.66.070.

The WMFFCA also protects whistleblowers. Any employee, contractor, or agent is entitled to all relief necessary to make that person whole if he is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment because of lawful acts done by the person in furtherance of a *qui tam* action or other efforts to stop a violation of the WMFFCA. Relief must include reinstatement with the same seniority status that the person would have had but for the discrimination, 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 attorneys' fees. A whistleblower must bring a claim within three years of the date when the retaliation occurred. Wash. Rev. Code Ann. § 74.66.090.

The Medicaid program rules do not contain *qui tam* provisions. However, they do provide that whistleblowers are entitled to the remedies enumerated in Wash. Rev. Code § 49.60 *et seq.* Wash. Rev. Code Ann. § 74.09.315.

What are the Penalties?

Violators of the WHCFCA are guilty of a Class C felony. Wash. Rev. Code Ann. § 48.80.030(6). Additionally, regulatory and disciplinary agencies will be informed of the conviction. Wash. Rev. Code Ann. § 48.80.060. Prosecution under the WHCFCA does not preclude action under any other applicable state law. Wash. Rev. Code Ann. § 48.80.050. 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. Wash. Rev. Code Ann. § 48.80.030(7).

At a maximum, violators of the WMFFCA face a civil penalty of up to \$10,957 to \$21,916, plus three times the amount of damages which the government entity sustains. Wash. Rev. Code Ann. § 74.66.020(1). The Washington Attorney General will annually adjust civil penalties to match the federal false claims act.³⁹ Additionally, a violator is responsible for the costs of litigation. Wash. Rev. Code Ann. § 74.66.020(3). 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(2).

Violators of the Medicaid program prohibition against fraudulent practices must repay any excess benefits or payments received, plus interest, and treble damages. Wash. Rev. Code Ann. § 74.09.210(2). Violation of the prohibition against false statements is a class C felony, and the court may impose a fine of no more than \$25,000. Wash. Rev. Code Ann. 74.09.230. Filling out an application, statement, or form that contains language stating it is made under the penalties of perjury with false or misleading information may be prosecuted as perjury.

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What is the Wisconsin law?

Effective July, 14, 2015, Wisconsin repealed its false claims act statute (Wis. Stat. § 20.931). Attempts to reinstate the law in early 2018 failed to pass in the Wisconsin Senate. However, the Medicaid program rules prohibit knowingly presenting or causing to be presented to any officer, employee, or agent of the state a false claim for medical assistance. Violators are liable for penalties of \$5,000-\$10,000 plus treble damages per claim. Wis. Stat. Ann. § 49.485. Under the section on medical assistance fraud, the rules prohibit intentionally making or causing to be made any false statement or representation of a material fact in any application for any Medical Assistance benefit or payment. This violation is a class H felony and carries a fine of no more than \$25,000. Wis. Stat. Ann. § 946.91.

³⁹Effective 6/7/2018, (S.B. 6053) ensures that state will recover the maximum penalty for the state in actions under WMFFCA. It is now the policy of the state to maintain compliance with the federal deficit reduction act (42 U.S.C. Sec. 1396h), and thereby obtain the additional ten percent share of state Medicaid fraud false claims act recoveries afforded by the federal deficit reduction act for compliant states, while encouraging *qui tam* whistleblower complaints to at least the same extent as the federal false claims act (31 U.S.C. Sec. 3729 *et seq.*).