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

ARKANSAS

What is the Arkansas 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), which provides for criminal sanctions in cases of Medicaid fraud. The AMFA became effective on December 31, 2005.[2] Both acts were amended by the 2017 Arkansas Laws Act 978 (S.B. 564).[3] 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 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

[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] 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.

[3] Effective August 1, 2017.

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.[4]

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 AFMA.[5] 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.[6] In addition, participation in the Medicaid program after being found guilty or pleading guilty or no contest in a Medicaid fraud charge is considered illegal Medicaid participation under the AMFA.

What are the Qui Tam Provisions and Whistleblower Protections?

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

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

Like federal law, the AWBA[7,8] prohibits public employers from discharging, discriminating, threatening or retaliating against public employees because of their: (1) good faith disclosure of information about a waste of public funds, property or manpower, or a suspected violation of a law, rule or regulation; (2) lawful participation in a false claims inquiry or administrative review; or (3) their refusal to assist employers in violating laws such as the Arkansas Medicaid Fraud False Claims Act and the Medicaid Fraud Act. Arkansas law does not appear to contain similar protections for non-public employees.

[4] Ark. Code Ann. § 20-77-902.

[5] 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.

[6] *See* 5-55-111(12) and (13) which are "knowingly," instead of purposely.

[7] 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 Adjourment.

[8] Effective August 1, 2017, H.B. 2055established 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.

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 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.[9] 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 (1) 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.[10]

COLORADO

What is the Colorado Medicaid False Claims Act?

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

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

[9] Amended by Arkansas Laws Act 978 (S.B. 564).

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

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

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

What are the Qui Tam Provisions and Whistleblower Protections?

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

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

What are the penalties?

The CMFCA establishes per claim financial penalties of $5,500 to $11,000,[11] 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.

IOWA

What is the Iowa False Claims Act & Iowa Medical Assistance Act?

The Iowa False Claims Act ("IFCA") (I.C. §§ 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")(I.C. § 249A.47) additionally deters providers from improperly filing claims by imposing sanctions. The IMAA became effective July 1, 2014.

[11] 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.

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.

What are the Qui Tam Provisions and Whistleblower Protections?

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

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

What are the Penalties?

The IFCA establishes financial penalties of $5,000 to $10,000 for each violation[12] 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.

The IMAA provides a civil penalty of not more than ten thousand dollars ($10,000) for each item or service.

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).

KANSAS

What is 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).[13] The KFCA became effective on April 30, 2009. In addition, Kansas has a

[12] 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.

[13] 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

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, 118-118a) which became effective on July 1, 2011.

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

Violations of the KMFCA 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

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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

(J) intentionally executing or attempting to execute a scheme or artifice to defraud the Medicaid program or any contractor or subcontractor thereof.

Violations of the KFIA include "an act committed by any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto."[14]

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.

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 $1,000[15] and $25,000; and (v) a class A nonperson misdemeanor if the payments illegally claimed are less than $1,000[16]. Additionally, when

[14] K.S.A. 40-2,118.

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

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

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 is the Kentucky Control of Fraud and Abuse Act?

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

Violations of the KCFA[17] 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

[17] 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

documents submitted to health and family services, or intentionally engage in conduct which advances the scheme or artifice; (2) intentionally, knowingly, or wantonly falsifying information used in determining rights to any benefit or payment; (3) misrepresenting the conditions or operations of a facility to qualify as a certified institution; and (4) knowingly falsify, conceal, or cover up by any trick, scheme, or device a material fact, or make any false, fictitious, or fraudulent statement or representation, or make or use any false writing or document knowing the same to contain any false, fictitious, or fraudulent statement or entry.

What are the Qui Tam Provisions and Whistleblower Protections?

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

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

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

What are the Penalties?

The criminal penalties for violating the KFCA include the following: A provider who violates subsections (1) and (2) are guilty of a Class A misdemeanor. However, in the event that the sum of all the benefits or payments claimed reaches three hundred dollars ($300)[18], the violation is classified Class D felony. Further, a provider who violates subsection (3) is guilty of a Class C felony. Lastly, any provider who violates the provisions of subsection (4) is guilty of a Class D felony.

The civil penalties for violating the KFCA include the following: (1) restitution 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.

MINNESOTA

What is the Minnesota False Claims Against the State Act?

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

Violations of the MFCASA 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 to defraud the state or a political

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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).

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

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.

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. 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.

NEBRASKA

What is the Nebraska False Medicaid Claims Act?

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

Violations of the FMCA include: (1) knowingly presenting or causes a false or fraudulent claim for payment or approval; (2) knowingly makes, uses or causes to be made or used, a false record or statement material[19] to a false or fraudulent claim; (3) conspiring to commit a violation of the FMCA; (4) having possession, custody, or control of property or money used or to be used by the state and knowingly delivers, or causes to be delivered, less than all of the money or property; (5) is authorized to make or deliver a document certifying receipt of property used, or to be used, by the state and, intending to defraud the state, makes or delivers the receipt knowing that the information on the receipt is not true; (6) knowingly buys or receives as a pledge of an obligation or debt, public property from any officer or employee of the state who may not lawfully sell or pledge such property; or (7) knowingly makes, uses or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the state or knowingly conceals, avoids, or decreases an obligation to pay or transmit money or property to the state.

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

The FMCA applies only to Medicaid claims.

What are the Qui Tam Provisions and Whistleblower Protections?
The FMCA *does not* contain provisions that allow individuals (or *qui tam* plaintiffs) with original information concerning fraud to file a lawsuit on behalf of the state.

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

NEW MEXICO

What is 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. §§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. [20] Second, is the Fraud Against Taxpayers Act ("FATA") (N.M. Stat. Ann. §§ 44-9-1 to 44-9-14), a civil statute

[19] "Material," is defined as "having a natural tendency to influence or be capable of influencing the payment or receipt of money or property."

[20] 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.

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. [21] The statutes are very similar, but the main difference is that the FATA is not exclusive to the Medicaid program like the MFCA. Finally, New Mexico maintains a general Medicaid Fraud Act ("MFA") (N.M.S.A. §30-44-7)[22] 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 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 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.[23]

Violations of the FATA include: (1) knowingly present, or cause 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 make or use, or cause 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) conspire to defraud the state or a political subdivision by obtaining approval or payment on a false or fraudulent claim; (4) conspire 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 deliver or cause 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 make or deliver a receipt that falsely represents a material characteristic of the property; (7) knowingly buy, or receive as a pledge of an obligation or debt, public property from any person that may not

[21] 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.

[22] 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.

[23] 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.

lawfully sell or pledge the property; (8) knowingly make or 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; or (9) as a beneficiary of an inadvertent submission of a false claim and having subsequently discovered the falsity of the claim, fail to disclose the false claim to the state or political subdivision within a reasonable time after discovery.[24]

Violations of the MFA include: (1) providing with intent that a claim be relied upon for the expenditure of public money: (a) treatment, services or goods that have not been ordered by a treating physician; (b) treatment that is substantially inadequate when compared to generally recognized standards within the discipline or industry; or (c) merchandise that has been adulterated, debased or mislabeled or is outdated; (2) presenting or causing to be presented for allowance or payment with intent that a claim be relied upon for the expenditure of public money any false, fraudulent, excessive, multiple or incomplete claim for furnishing treatment, services or goods; or (3) executing or conspiring to execute a plan or action to: (a) defraud a state or federally funded or managed health care plan in connection with the delivery of or payment for health care benefits, including engaging in any intentionally deceptive marketing practice in connection with proposing, offering, selling, soliciting or providing any health care service in a state or federally funded or mandated managed health care plan; or (b) obtain by means of false or fraudulent representation or promise anything of value in connection with the delivery of or payment for health care benefits that are in whole or in part paid for or reimbursed or subsidized by a state or federally funded or mandated managed health care plan. This includes representations or statements of financial information, enrollment claims, demographic statistics, encounter data, health services available or rendered and the qualifications of persons rendering health care or ancillary services.[25]

What are the Qui Tam Provisions and Whistleblower Protections?

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

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

What are the Penalties?

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

Similarly, the remedies provided for in the FATA are not exclusive and shall be in addition to any other remedies provided for in any other law or available under common law. A FATA violation provides for

[24] 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.

[25] 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.

financial penalties of $5,000 to $10,000 for each violation plus three times the amount of damages to the State may be imposed, as well as the costs of a civil action to recover penalties or damages and reasonable attorney fees. The courts reduce damages for violations if the false claims are voluntarily disclosed. Such civil actions must be brought within four years.

Finally, the remedies under the MFA are separate from and cumulative to any other administrative and civil remedies available under federal or New Mexico law or regulation. Whoever commits Medicaid fraud in violation of the MFA may be subject to both civil and criminal penalties and sentencing procedures.[26] For example, if any person who receives payment for furnishing treatment, services or goods under Medicaid, which payment the person is not entitled to receive by reason of a violation of the MFA, shall, in addition to any other penalties or amounts provided by law, be liable for: (1) payment of interest on the amount of the excess payments at the maximum legal rate in effect on the date the payment was made, for the period from the date payment was made to the date of repayment to the state; (2) a civil penalty in an amount of up to three times the amount of excess payments; (3) payment of a civil penalty of up to ten thousand dollars ($10,000) for each false or fraudulent claim submitted or representation made for providing treatment, services or goods; and (4) payment of legal fees and costs of investigation and enforcement of civil remedies. No action under this section shall be brought after the expiration of five years from the date the action accrues.

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

NORTH DAKOTA

What are the North Dakota Medicaid Provider Integrity Laws and Regulations?

North Dakota is one of two remaining states in the United States that has not established a Medicaid Fraud Control Unit overseen by the government.[27] Although North Dakota does not have an official state false claims act,[28] North Dakota's Medicaid provider integrity laws and regulations impose liability on those who submit false claims for the purpose of obtaining government funds. (*See generally* Medicaid Provider Integrity, N.D. Cent. Code § 50-24.1-01.3; N.D. Admin. Code §§ 75-02-05-01 to 75-02-05-08; 72-02-06-02(4); Remedies N.D. Cent. Code §§ 32-03-01 to 32-03-56; and Whistleblower Protections, N.D. Cent. Code §§ 34-01-20; N.D. Cent.

[26] 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.

[27] H.B. 1226, signed by the governor in March 2017, provides for a study of the feasibility and desirability of establishing a Medicaid Fraud Control Unit. Before August 1, 2018, the department shall report to the legislative management the outcome of this study, together with any legislation required to implement the recommendations.

[28] Proposed legislation (H.B. 1226 and H.B. 1227) would create and enact new laws relating to the creation of a Medicaid fraud control unit the Attorney General's office (adding four new sections to chapter 54-12 of the North Dakota Century Code); and provide a penalty for Medicaid fraud (adding a new section to chapter 12.1-31 of the North Dakota Century Code). H.B. 1227 failed to pass at a second reading in February 2017. H.B. 1226 passed and was signed into law by the Governor 3/17/2017.

Code § 50.10.1-05; and N.D. Admin. Code § 75-03-25-13, prohibiting retaliatory action for providing information to the long-term care ombudsman).

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

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

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

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

OHIO

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

The chief actions that violate this law are (1) knowingly making or causing to be made a false or misleading statement or representation for use in obtaining reimbursement from the medical assistance program, (2) purposefully and knowingly charging, soliciting, accepting or receiving any property, money or other consideration in addition to the amount of reimbursement under the medical assistance program to which the person would otherwise be entitled, (3) purposefully and knowingly soliciting, offering or receiving any remuneration, other than authorized deductibles or co-payments, in cash or in kind, including, but not limited to, a kickback or rebate, in connection with the furnishing of goods or services for which whole or partial reimbursement is or may be made under the medical assistance program, and (4) knowingly altering, falsifying, destroying, concealing, or removing any records within six years after submitting a claim under the medical assistance program that are necessary to fully disclose the nature of all goods and services on which the claim was submitted or for which reimbursement was received or that are necessary to disclose fully all income and expenditures upon which rates or reimbursement were based.

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

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

What are the Qui Tam Provisions and Whistleblower Protections?

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

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

What are the Penalties?

(A) The attorney general may bring a civil action in the Franklin county court of common pleas on behalf of the department of Medicaid, and the prosecuting attorney of the county in which a violation of division (B) of section 2913.401 of the Revised Code occurs may bring a civil action in the court of common pleas of that county on behalf of the county department of job and family services, against a person who violates division (B) of section 2913.401 of the Revised Code for the recovery of the amount of benefits paid on behalf of a person that either department would not have paid but for the violation minus any amounts paid in restitution under division (C)(2) of section 2913.401 of the Revised Code and for reasonable attorney's fees and all other fees and costs of litigation (Ohio Rev. Code Ann. § 2307.65) Violations of Section 2913.40 (related to Medicaid fraud), Section 2913.401 (related to Medicaid eligibility fraud), and Section 2921.13 (related to certain false statements) result in penalties ranging from a first degree misdemeanor to a third, fourth or fifth degree felony, depending on the value of the property, services or funds obtained.

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

OREGON

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

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

Violations of the OFCA include: (1) presenting or causing to be presented for payment or approval a claim that the person knows is false; (2) in the course of presenting a claim for payment or approval, making or using a false record or statement that the person knows to contain, or to be based on, false or fraudulent information; (3) agreeing or conspiring with other persons to present for payment or approval a claim that the person knows is a false claim; (4) delivering, or causing to be delivered, property to a public agency in an amount the person knows is less than the amount for which the person receives a certificate or receipt; (5) making or delivering a

document certifying receipt of property used by a public agency, or intended to be used by a public agency, that the person knows contains false or fraudulent information; (6) buying property of a public agency from an officer or employee of a public agency if the person knows that the officer or employee is not authorized to sell the property; (7) receiving property of a public agency from an officer or employee of the public agency as a pledge of an obligation or debt if the person knows that the officer or employee is not authorized to pledge the property; (8) making or using, or causing to be made or used, a false or fraudulent statement to conceal, avoid or decrease an obligation to pay or transmit moneys or property to a public agency if the person knows that the statement is false or fraudulent; or (9) failing to disclose a false claim that benefits the person within a reasonable time after discovering that the false claim has been presented or submitted for payment or approval.

Violations of the OFCHCP occur when a person, defined as an individual, corporation, partnership or association providing health care services or any other form of legal or business entity providing health care services, does the following: (1) knowingly makes or causes to be made a claim for health care payment that contains any false statement or false representation of a material fact in order to receive a health care payment; or (2) knowingly conceals from or fails to disclose to a health care payor the occurrence of any event or the existence of any information with the intent to obtain a health care payment to which the person is not entitled, or to obtain or retain a health care payment in an amount greater than that to which the person is or was entitled.

What are the Qui Tam Provisions and Whistleblower Protections?

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

What are the Penalties?

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

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

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

PENNSYLVANIA

What are the Pennsylvania Fraud and Abuse Control Act & Pennsylvania Whistleblower Law?

Pennsylvania maintains a Fraud and Abuse Control Act ("PFAC") (62 P.S. § 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 for services, supplies, or equipment which are not documented in the record in the prescribed manner and are of little or no benefit to the recipient, are below the accepted medical treatment standards, or are unneeded by the patient; (5) submitting a claim which misrepresents the description of services, supplies or equipment dispensed or provided; the dates of services; the identity of the recipient; the identity of the attending, prescribing or referring practitioner; or the identity of the actual provider; (6) submitting a claim for reimbursement for a service, charge or item at a fee or charge which is higher than the provider's usual and customary charge to the general public for the same service or item; or (7) submitting a claim for a service or item which was not rendered by the provider.

What are the Qui Tam Provisions and Whistleblower Protections?

Separate from the PFAC, Pennsylvania has a Pennsylvania Whistleblower Law ("PWL") (43 P.S. §§ 1421 to 1428), which provides protection from discrimination and retaliation to any person who witnesses or has evidence of wrongdoing or waste while employed by a public body and who makes a good faith report of the wrongdoing or waste to one of the person's superiors, to an agent of the employer or to an appropriate authority. The PWL further provides that no employer may discharge, threaten or otherwise discriminate or retaliate against an employee after he makes such a good faith report. Further, after making a report to the appropriate authorities, the authority is prohibited from disclosing the identity of the whistleblower without his/her consent, unless 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 fifteen thousand dollars ($15,000) and seven years imprisonment. Whenever any person has been previously convicted in any state or Federal court of conduct that would constitute a violation of the PFAC, a subsequent allegation, indictment or information under the PFAC shall be classified as a felony of the second degree with a maximum penalty of twenty-five thousand dollars ($25,000) and ten years imprisonment. In addition, the trial court shall order any person convicted under the PFAC to: (i) repay the amount of the excess benefits or payments plus interest on that amount at the maximum legal rate from the date payment was made by the Commonwealth to the date repayment is made to the Commonwealth and (ii) pay an amount not to exceed threefold the amount of excess benefits or payments. Further, any person convicted under the PFAC shall be ineligible to participate in Medicaid for a period of five years from the date of conviction.

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

Furthermore, if retaliatory actions arising out of a PFAC violation in turn violate the PWL, it can yield additional civil penalties, including a fine of not more than $10,000.

TENNESSEE

What is the Tennessee Medicaid False Claims Act, Tennessee False Claims Act & TennCare Fraud and Abuse Reform 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. Finally, Tennessee maintains a TennCare Fraud and Abuse Reform Act of 2004 ("TFAR") (T. C. A. § 71-5-2501 *et seq.*) which aims at preventing fraud and abuse of the state Medicaid program, called TennCare.

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

A violation of the TFAR occurs when a person, firm, corporation, partnership or any other entity: (1) knowingly obtains, or attempts to obtain, or aids or abets any person or entity to obtain, by means of a willfully false statement, report, representation, claim or impersonation, or by concealment of any material fact, or by any other fraudulent means, including knowingly presenting or causing to be presented to TennCare or any of its contractors, subcontractors or vendors a false or fraudulent claim for payment or approval, or in any manner not authorized by any rule, regulation, procedure, or statute governing TennCare, medical assistance payments provided pursuant to any rule, regulation, procedure, or statute governing TennCare to which the person or entity is not entitled, or of a greater value than that to which the person or entity is authorized; or (2) provides a willfully false statement regarding another's medical condition or eligibility for insurance, to aid or abet another in obtaining or attempting to obtain medical assistance payments, medical assistance benefits or any assistance provided under any rule, regulation, procedure, or statute governing TennCare to which the person is not entitled or to a greater value than that to which such person is authorized.

What are the Qui Tam Provisions and Whistleblower Protections?

The TFCA and TMFCA contain provisions that allow individuals (or *qui tam* plaintiffs) with "original" information concerning fraud to file a lawsuit on behalf of the state. This means that a *qui tam* plaintiff must (1) have direct and independent knowledge of the information on which the allegations are based, (2) voluntarily

provide this information to the state or political subdivision before filing an action based on that information, and (3) have provided the basis or catalyst for the investigation, hearing, audit, or report that led to the public disclosure of allegations. (22 Tenn. Prac. Contract Law and Practice § 13:72 (2012)).

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

Both the TFCA and TMFCA 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.

What are the Penalties?

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

An individual who violates subsection the TFAR is guilty of either (i) a Class B felony when the value of the services unlawfully obtained is between sixty thousand dollars ($60,000) and two hundred fifty thousand dollars ($250,000); (ii) a Class C felony if the value of the services unlawfully obtained is between ten thousand dollars ($10,000) and sixty thousand dollars ($60,000); or (iii) a Class D felony when the value of services unlawfully obtained is between one thousand dollars ($1,000) and ten thousand dollars ($10,000). Additionally, in addition to any other penalty, a sentence that includes a fine, when imposed upon an entity or upon a person for actions benefiting an entity shall include a corporate fine, determined by a jury, as follows: (a) for a Class B felony, between eight (8) and fifteen (15) years imprisonment and a fine not to exceed fifty thousand dollars ($50,000); (b) for a Class C felony, between three (3) and fifteen (15) years imprisonment and a fine not to exceed ten thousand dollars ($10,000); (c) for a Class D felony, between two (2) and twelve (12) years imprisonment and a fine not to exceed five thousand dollars ($5,000).

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

TEXAS

What is the Texas Medicaid Fraud Prevention Act?

The Texas Medicaid Fraud Prevention Act ("TMFPA") (Tex. Hum. Res. Code §§ 36.001-132) establishes a cause of action for false claims for payment from the Medicaid program. The TMFPA provides that the Attorney General or a private citizen may prosecute cases under the TMFPA, and grants the Attorney General

the authority to issue civil investigation demands to investigate potential Medicaid fraud. The TMFPA became effective on September 1, 1995.[29]

Violations of the TMFPA include: (1) knowingly making or causing to be made a false statement or misrepresentation of a material fact to permit a person to receive a benefit or payment under the Medicaid program that is not authorized or that is greater than the benefit or payment that is authorized; (2) knowingly concealing or failing to disclose information that permits a person to receive a benefit or payment under the Medicaid program that is not authorized or that is greater than the benefit or payment that is authorized; (3) knowingly applying for and receiving a benefit or payment on behalf of another person under the Medicaid program and converting any part of the benefit or payment to a use other than for the benefit of the person on whose behalf it was received; (4) knowingly making, causing to be made, inducing, or seeking to induce the making of a false statement or misrepresentation of material fact concerning: (i) the conditions or operation of a facility in order that the facility may qualify for certification or recertification required by the Medicaid program, including certification or recertification as a hospital; a nursing facility or skilled nursing facility; a hospice; an intermediate care facility for the mentally retarded; an assisted living facility; or a home health agency; or (ii) information required to be provided by a federal or state law, rule, regulation, or provider agreement pertaining to the Medicaid program; (5) except as authorized under the Medicaid program, knowingly paying, charging, soliciting, accepting, or receiving, in addition to an amount paid under the Medicaid program, a gift, money, a donation, or other consideration as a condition to the provision of a service or product or the continued provision of a service or product if the cost of the service or product is paid for, in whole or in part, under the Medicaid program; (6) knowingly presenting or causing to be presented a claim for payment under the Medicaid program for a product provided or a service rendered by a person who (i) is not licensed to provide the product or render the service, if a license is required; or (ii) is not licensed in the manner claimed; (7) knowingly making or causing to be made a claim under the Medicaid program for (i) a service or product that has not been approved or acquiesced in by a treating physician or health care practitioner; (ii) a service or product that is substantially inadequate or inappropriate when compared to generally recognized standards within the particular discipline or within the health care industry; or (iii) a product that has been adulterated, debased, mislabeled, or that is otherwise inappropriate; (8) making a claim under the Medicaid program and knowingly failing to indicate the type of license and the identification number of the licensed health care provider who actually provided the service; (9) conspiring to commit a violation of the TMFPA; (10) is a managed care organization that contracts with the Health and Human Services Commission or other state agency to provide or arrange to provide health care benefits or services to individuals eligible under the Medicaid program and knowingly (i) fails to provide to an individual a health care benefit or service that the organization is required to provide under the contract; (ii) fails to provide to the commission or appropriate state agency information required to be provided by law, commission or agency rule, or contractual provision; or (iii) engages in a fraudulent activity in connection with the enrollment of an individual eligible under the Medicaid program in the organization's managed care plan or in connection with marketing the organization's services to an individual eligible under the Medicaid program; (11) knowingly obstructing an investigation by the Attorney General of an alleged unlawful act under this section; (12) knowingly making, using, or causing the making or use of a false record or statement material to an obligation to pay or transmit money or property to this state under the Medicaid program, or knowingly concealing or knowingly and improperly avoiding or decreasing an obligation to pay or transmit money or property to this state under the Medicaid program; or (13) knowingly engaging in conduct that constitutes a violation of the Texas Medical Assistance Program.

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

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

Texas provides for robust whistleblower protections and a person, including an employee, contractor, or agent, who is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment because of a lawful act taken by the person or associated others in furtherance of an action under the TMFPA, including investigation for, initiation of, testimony for, or assistance in an action filed or to be filed, or other efforts taken by the person to stop one or more violations of Texas Medical Assistance Program is entitled to: (1) reinstatement with the same seniority status the person would have had but for the discrimination; and (2) not less than two times the amount of back pay, interest on the back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorney's fees. However, a person must bring suit on an action under this section not later than the third anniversary of the date on which the cause of action accrues (the date the retaliation occurs).

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

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

WASHINGTON

What are the Washington Health Care False Claims Act & Medicaid Fraud False Claims Act?
Washington has two false claims acts. The Washington Health Care False Claim Act ("WHCFCA") is a state law directed at eliminating the costs of fraudulent health care claims by establishing specific penalties and deterrents through Washington's Insurance Code. (Rev. Code Wash. §§ 48.80.010 to 48.80.900). The Washington Medicaid Fraud False Claims Act ("WMFFCA") (Wash. Rev. Code Ann. § 74.66.005 *et seq.*)[30] provides similar penalties and deterrents aimed specifically at false Medicaid claims.

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

[30] 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.

amount from an insured knowing that it is in violation of an agreement or contract with a health care payor to which the provider is a party.

Similarly, WMFFCA violations occur when a person (a) knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval; (b) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim; (c) conspires to commit a WMFFCA violation; (d) has possession, custody, or control of property or money used, or to be used, by the government entity and knowingly delivers, or causes to be delivered, less than all of that money or property; (e) is authorized to make or deliver a document certifying receipt of property used, or to be used, by the government entity and, intending to defraud the government entity, makes or delivers the receipt without completely knowing that the information on the receipt is true; (f) knowingly buys, or receives as a pledge of an obligation or debt, public property from an officer or employee of the government entity who lawfully may not sell or pledge property; or (g) knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the government entity, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the government entity.

What are the Qui Tam Provisions and Whistleblower Protections?

The WHCFCA *does not* contain provisions that allow individuals (or *qui tam* plaintiffs) with original information concerning fraud to file a lawsuit on behalf of the state. However, the WMFFCA contains a provision allowing *qui tam* plaintiffs to initiate an action.

What are the Penalties?

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

At a maximum, violators of the WMFFCA face a civil penalty of up to $5,500 to $11,000, plus three times the amount of damages which the government entity sustains. The Washington Attorney General will annually adjust civil penalties to match the federal false claims act.[31] Additionally, a violator is responsible for the costs of litigation. (Wash. Rev. Code Ann. § 74.66.020). At a minimum, the court must award no less than two times the amount of damages incurred, even if (1) the violator came forward with relevant information within 30 days of obtaining it; (2) the violator fully cooperated with the investigation; and (3) or the violator had no actual knowledge of the investigation into the violation and at the time, no criminal, civil or administrative action had commenced. (Wash. Rev. Code Ann. § 74.66.020).

WISCONSIN

What is the Wisconsin 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.

[31]Effective 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.).