OVERVIEW OF RELEVANT HEALTHCARE LAWS

POLICY:

There are several federal and state fraud and abuse laws that govern the healthcare industry. All employees of any EmCare Company must strictly follow these laws. The following laws are particularly applicable:

A. The Federal Anti-Kickback Statute
B. The Federal Anti-Kickback Safe Harbors and Exceptions
C. The Federal Self-Referral “Stark Law” Statute
D. The Federal False Claims Statute
E. The Program Fraud Civil Remedies Act;
F. State False Claims Acts; and
G. The Federal Laws Governing Consumer Inducements

The policies included in EmCare’s Corporate Compliance Program have been developed as a result of these specific healthcare laws and regulations.

Each law is discussed briefly below. If you have questions, you should consult your immediate supervisor, EmCare’s Legal Department or EmCare’s Compliance Officer.

A. THE FEDERAL ANTI-KICKBACK STATUTE

Overview

The Federal Healthcare Program Anti-Kickback Statute (the “Anti-Kickback Statute”), (U.S.C. §1320a-7b), imposes criminal penalties on individuals and entities that knowingly and willfully solicit or receive remuneration “in return for referring an individual to a person for the furnishing or arranging for the furnishing of an item or service” or “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… a federal healthcare program. ”

Prohibited Inducements

The Anti-Kickback Statute prohibits a person from knowingly and willfully offering or paying remuneration to any person to induce that person to refer or purchase, lease, order
or arrange for or recommend the purchasing, leasing or ordering of items or services for which payment may be made by a federal healthcare program.

The types of remuneration prohibited by the Anti-Kickback Statute include, but are not limited to, kickbacks, bribes and rebates. Additionally, the Anti-Kickback Statute expressly prohibits both “direct” and “indirect” remuneration.

**Penalties**

Any person convicted of knowingly and willfully violating the Anti-Kickback Statute shall be found guilty of a felony, and fined not more than $25,000 or imprisoned for not more than 5 years, or both, for each violation. Violators of the Anti-Kickback Statute also are subject to exclusion from federal healthcare programs upon a determination of a violation by the Secretary of Health and Human Services (“HHS”), regardless of whether a criminal conviction has been obtained. In addition, the Balanced Budget Act of 1997 grants the Secretary of HHS new authority to impose civil monetary penalties for each violation of the Anti-Kickback Statute of: (a) up to $50,000; and (b) three times the amount of the remuneration in question.

**B. THE FEDERAL ANTI-KICKBACK SAFE HARBORS AND EXCEPTIONS**

**Overview**

The Anti-Kickback Statute includes limited statutory exceptions for certain financial arrangements, specifically an exception for employment arrangements. Additionally, the Department of Health and Human Services (“DHHS”) has promulgated regulations, termed “safe harbors,” specifying certain payment practices that are exempted from the prohibitions of the Anti-Kickback Statute. 42 C.F.R. §1001.952, *et seq.* However, the protection afforded by the safe harbor regulations is limited to very narrow circumstances.

**The Statutory Exception For Employment Arrangements and the Employment Safe Harbor**

The Anti-Kickback Statute includes a statutory exception for “any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services.” The safe harbor regulations also address employment arrangements but narrow the statutory exception through the definition of “employee”. Specifically, the safe harbors provide that the term “employee” has the same meaning as it does for purposes of (26 U.S.C.}

**Overview of Relevant Healthcare Laws**

**Revised – December 2006**
§3121)(d)(2), which adopts the “usual common law rules.” Nevertheless, DHHS also considers the purpose of the employment, the amount paid for the service, and whether services were performed, in assessing the employment relationship, and might be expected to challenge “sham” employment arrangements despite the arguably blanket protection of this exception.

**The Statutory Exception For Discounts and the Discount Safe Harbor**

The Anti-Kickback Statute includes a statutory exception for “a discount or other reduction in price obtained by a provider of services or other entity under a federal healthcare program if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity.” The discount safe harbor regulation narrows the statutory exception through its restrictive definition of the word “discount”. Specifically, the discount safe harbor regulation restricts the term “discount” by excluding such typical discount arrangements as: discounted or free items or services in exchange for the purchase of different items or services; discounts not applicable to Medicare or Medicaid; and, discounts given directly to beneficiaries (for example, waivers of co-insurance). The discount safe harbor also prescribes specific disclosure standards for different categories of purchasers. All purchasers other than those who file cost reports can only take advantage of discounts made at the time of the original sale. The July 1994 proposed “clarification” regulations would prohibit rebates for non-cost reporting purchasers, would not require such purchasers to reduce their charges by the full amount of the discount and would require such purchasers to report discounts only if the item is separately claimed for payment or if the Medicare or state health program requests such information.

**The Space and Equipment Rental and Personal Services and Management Agreement Safe Harbors**

The regulations create safe harbors for certain contracts for space and equipment rental and personal services and management contracts. These three separate safe harbors are virtually identical in their requirements. For each safe harbor, a written agreement must be executed. The term of the agreement must be for at least one (1) year and must specify the aggregate payment amount as well as the premises, equipment, or services covered. If the agreement does not contemplate full-time services, the agreement must also specify the schedule of intervals, their precise length, and the exact charge for such intervals. In addition, the payments must be based upon fair market value, and not vary on the volume or value of any federal healthcare program covered referrals or business generated between the parties. The services performed under the agreement must not involve the counseling or promotion of a business activity or other activity that violates any state or federal law.
Compliance with Safe Harbor Provisions is Voluntary

Compliance with the terms of each criterion in a safe harbor regulation is voluntary. Although compliance with these safe harbor regulations assures an entity or an individual that a particular practice does not violate the Anti-Kickback Statute, an action or arrangement that does not satisfy each criterion of a safe harbor does not necessarily violate the Anti-Kickback Statute. Rather, that financial arrangement merely lacks the assurance that it is protected from liability under the Anti-Kickback Statute.

C. THE FEDERAL SELF-REFERRAL “STARK LAW” STATUTE

Overview

The Federal Self-Referral Law (the “Stark Law”), (42 U.S.C. §1395nn; 42 C.F.R. §411), prohibits a physician who has a financial relationship with an entity (or whose immediate family member has a financial relationship with an entity) from making a “referral” of a Medicare or Medicaid patient to that entity for the furnishing of “designated health services” for which payment may be made under the Medicare or Medicaid programs for items and services ordered by a physician who has a financial relationship with the entity.

Definitions

- The term “financial relationship” is defined in the Stark Law to include both compensation arrangements as well as ownership and investment interests.
- The phrase “designated health services” includes among other services, in-patient and outpatient hospital services, clinical laboratory services and home health services.
- “Physician” means a doctor of medicine or osteopathy legally authorized to practice medicine and surgery; a doctor of dental surgery or dental medicine legally licensed to practice dentistry; a doctor of optometry; and a chiropractor.

Exception for Bona Fide Employment Relationships

The Stark Law includes an exception for compensation paid by an employer to an employee under a bona fide employment relationship so long as the employment is for identifiable services, the amount of payment is consistent with fair market value, the compensation is not determined in a manner that takes into consideration the volume or
value of any referrals that were made to the employer. Although the exception includes a requirement that the payment not be determined based on the volume or value of referrals, exempted from the exception are payments in the form of productivity bonuses based on services performed personally by the physician.

**Exception for Personal Service Arrangements**

The Stark Law excepts certain compensation arrangements between a physician and an entity where the physician is an independent contractor and not an employee. In order to qualify for the exception, these personal service arrangements must be set out in writing, describe the services covered, have a term of at least one year, determine that payment in advance in a manner that reflects fair market value and not the volume or value of any referrals or business generated between the parties and the services performed under the arrangement must not involve the counseling or promotion of a business arrangement or other activity that violates any state or federal law.

**Exception for Unrelated Payments**

The Stark Law also exempts payment provided by a hospital to a physician if such payments do not relate to the provision of designated health services. The preamble to the Stark I regulation (applicable to clinical laboratory services) states that this exception does not extend to entities affiliated with a hospital, but only to the entity or entities meeting the regulation’s definition of hospital.

**Exception for Items or Services**

There is an exception under the Stark Law that protects payments made by a physician to an entity as compensation for items or services other than clinical laboratory services if the items or services are furnished at a price that is consistent with fair market value.

D. THE FEDERAL FALSE CLAIMS STATUTE

**Overview**

The Federal False Claims Act (“FCA”) prohibits anyone from *knowingly* presenting, or *causing to be presented*, a false or fraudulent claim in order to secure payment from the federal government. A person found to have violated this statute is liable of not less than $5,000 and not more than $10,000 for each claim, plus three times the amount of damages sustained by the federal government. The False Claims Act defines “knowing” and “knowingly” as: actual knowledge; deliberate ignorance of the truth or reckless disregard of the truth or falsity. Therefore, no proof of specific intent to defraud is required to demonstrate a violation of this Act.
The FCA helps the federal government combat fraud and recover losses resulting from fraud in federal programs, purchases, or contracts. A person or entity may violate the FCA by knowingly: (1) submitting a false claim for payment, (2) making or using a false record or statement to obtain payment for a false claim, (3) conspiring to make a false claim or get one paid, or (4) making or using a false record to avoid payments owed to the U.S. government. Lawsuits must be filed by the later of either: (1) three years after the violation was discovered by the federal official responsible for investigating violations (but no more than ten years after the violation was committed), or (2) six years after the violation was committed.

**Qui Tam Actions and Whistleblower Protections**

An individual also has the right to file a civil suit for him or herself and for the government to challenge a FCA violation. The suit must be filed in the name of the government. Such an individual is called a *qui tam* plaintiff or “relator”. Successful relators may receive between 15 and 30 percent of the total amount recovered (plus reasonable costs and attorney fees) depending on the involvement of the relator and whether the government prosecuted the case. An individual cannot file a lawsuit based on public information, unless he or she is the original source of the information.

The FCA contains important protections for whistleblowers. Employees who report fraud and consequently suffer discrimination are entitled to all relief necessary to be made whole, including two times their back pay plus interest, reinstatement at the seniority level they would have had except for the discrimination, and compensation for any costs or damages they have incurred.

**E. THE PROGRAM FRAUD CIVIL REMEDIES ACT**

Under the Program Fraud Civil Remedies Act, federal law also provides for administrative remedies against providers for false claims and statements, in the amount of $5,000 for each false claim or statement, and an assessment of up to twice the amount of such claim. These administrative civil remedies are described further in the Program Fraud Civil Remedies Act, 31 U.S.C. Sections 3801-3812.

A “false claim” (for purposes of the administrative remedies) is defined as a claim that the person knows or has reason to know (i) is false or fraudulent, (ii) includes or is supported by any written statement which asserts a material fact which is false, (iii) includes or is supported by any written statement that omits a material fact, is false as a result of such omission, and is a statement in which the person making such statement has a duty to include such material fact, or (iv) is for payment for the provision of property or services which the person has not provided as
claimed. A “false statement” is defined as a statement that the person knows or has reason to know asserts a material fact that is false or omits a material fact that makes the statement false.

F. STATE FALSE CLAIMS ACTS

Many states in which EmCare does business also have state false claims acts that prohibit anyone from knowingly presenting, or causing to be presented, a false or fraudulent claim in order to secure payment from local and/or state government. Many of these state false claims acts are similar to the federal FCA and provide for lawsuits either by the government or a qui tam plaintiff (or “relator”). Many of these laws also include whistleblower protections similar to the federal FCA. A summary of the relevant provisions of the state FCAs in those states in which EmCare conducts business is attached as Attachment 1 to this Policy.

G. THE FEDERAL LAWS GOVERNING CONSUMER INDUCEMENTS

Health Insurance Portability and Accountability Act

The Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) specifically created a new provision which authorized the imposition of civil money penalties for offering inducements to individuals eligible for Medicare or Medicaid if the offeror knows or should know that it will influence the patient to order or receive items or services from a particular provider, practitioner or supplier. Significantly, the statute defines remuneration as including the waiver of co-insurance and deductibles and transfers of items or services for free or for other than fair market value. However, there are limited exceptions provided in the statute. For instance, co-insurance waivers that are based on financial need and meet other requirements are protected. Additionally, in light of the potential application of this provision to managed care arrangements, the statute excepts from the scope of illegal remuneration differentials in co-insurance and deductible amounts that are part of the benefit plan design – e.g. as part of a PPO or similar managed care product – and that are disclosed and meet other standards to be defined by HHS. There also is an exception for incentives given to individuals to promote the delivery of preventive care as determined by HHS in regulations.
ATTACHMENT 1

SUMMARY OF RELEVANT STATE FALSE CLAIMS LAWS

EmCare State False Claims Acts Information

As referenced in Section F of this Policy, the following are detailed summaries of the state false claims acts in states in which EmCare operates. This information is intended to comply with Section 6032 of the Deficit Reduction Act of 2005. If you have any questions regarding these summaries or other state laws, please contact the Ethics and Compliance Department.
ALABAMA

The state of Alabama has not adopted any false claims acts or statutes that contain qui tam or whistleblower provisions that are similar to those found in the federal False Claims Act. It has, however, adopted a Medicaid anti-fraud statute that makes it unlawful for a person to submit false and fraudulent claims to the Alabama Medicaid program. Violations of the statute are criminal offenses punishable by imprisonment and/or significant monetary penalties. See Ala. Code § 22-1-11.
AR KANSAS

The Arkansas Medicaid Fraud Act ("AMFA") provides for criminal sanctions in cases of fraud under the Medicaid Program. Ark. Code Ann. § 5-5-101.1

Liability and Damages

- Actions that violate the AMFA include: (1) Purposefully making (or causing to be made) false statements or concealing relevant knowledge in regard to any benefit or payment under the Arkansas Medicaid Program or in regard to the condition or operation of an entity as regards certification; (2) purposely converting a benefit to a use other than for the use and benefit of the other person; (3) purposely soliciting or receiving any remuneration (kickback, bribe, or rebate) in exchange for certain referrals or recommendations; (4) purposely charging in excess of the rates established by the state or requiring funds additional to those paid by the program as a condition of admission or continued stay.

- Penalties of full restitution, a mandatory fine of three times the total amount of the false claims, and a fine of up to $3,000 per claim may be imposed. Any monetary penalties imposed under the AMFA are additional to those imposed by the AMFFCA. Additionally, violating the AMFA is a Class A misdemeanor if the aggregate amount of violations is under $200, a Class C felony if the aggregate amount is between $200 and $2,500, and a Class B felony if the aggregate amount is over $2,500. There may be additional fines associated with criminal conviction.

- The AMFA applies only to Medicaid claims.

Qui Tam Actions/Whistleblower Protections

- Under the AMFA, individuals who report fraud to the Attorney General receive up to ten percent of the total amount recovered, but in no case will an individual receive more than $100,000.

- Persons who provide access to records to the state are not subject to civil or criminal liability.

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ARIZONA

The state of Arizona has not adopted any false claims acts or statutes that contain qui tam or whistleblower provisions that are similar to those found in the federal False Claims Act. It has, however, adopted fraud and false statement statutes that make it unlawful for a person to submit false and fraudulent statements or claims to an Arizona state department or agency. Violations of these statutes are civil and criminal offenses and are punishable by imprisonment and significant monetary penalties and assessments. See Ariz. Rev. Stat. §§ 13-2310, 13-2311, 36-2918 and 36-2957.
CALIFORNIA

The California False Claims Act ("CFCA") applies to fraud involving state, city, county or other local government funds. Cal. Gov’t Code §§ 12650-12655. The CFCA encourages voluntary disclosure of fraudulent activities by rewarding individuals who report fraud and allowing courts to waive penalties for organizations that voluntarily disclose false claims.

Liability and Damages/Statute of Limitations

- The actions that violate the CFCA include: (1) submitting a false claim for payment, (2) making or using a false record to get a false claim paid, (3) conspiring to make a false claim or get one paid, or (4) making or using a false record to avoid payments owed to the state or local government. In addition, anyone who benefits from a false claim that was mistakenly submitted violates the CFCA if he or she does not disclose the false claim to the state or local government within a reasonable time after discovery of the false claim.

- The maximum civil penalty is $10,000, per claim. Persons who violate the CFCA may be liable to the state for three times the amount of damages that the state sustains because of the violation. The court can waive penalties and reduce damages for CFCA violations if the false claims are voluntarily disclosed. The CFCA does not apply to false claims of less than $500.

- Lawsuits must be filed within three years after the violation was discovered by the state or local official who is responsible for investigating the false claim (but no more than ten years after the violation was committed).

Private or Qui Tam Actions/Whistleblower Provisions

- Individuals (or qui tam plaintiffs) can sue for violations of the CFCA. Individuals who bring an action under the CFCA receive between 15 and 33 percent of the amount recovered (plus reasonable costs and attorney’s fees) if the state prosecutes the case, and between 25 and 50 percent (plus reasonable costs and attorney’s fees) if the qui tam plaintiff litigates the case on his or her own.

- An individual cannot file a lawsuit based on public information, unless he or she is the original source of the information.

- The CFCA bars employers from interfering with an employee’s disclosure of false claims. Employees who report fraud and consequently suffer discrimination 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, (3) compensation for any costs or damages they have incurred, and (4) punitive damages, if appropriate.
COLORADO

The state of Colorado has not adopted any false claims acts or statutes that contain *qui tam* or whistleblower provisions that are similar to those found in the federal False Claims Act. It has, however, adopted a generally applicable Medicaid anti-fraud statute that is intended to prevent the submission of false and fraudulent claims to the Colorado Medicaid program. The statute makes it unlawful for any person to make a false representation of material fact, present a false claim for payment or approval, or present a false cost document in connection with a claim for payment or reimbursement from the Colorado Medicaid program. Violations of the Colorado anti-fraud statute are civil offenses and are punishable by significant monetary penalties. See C.R.S.A. § 25.5-4-305.
The state of Connecticut has not adopted any false claims acts or statutes that contain *qui tam* or whistleblower provisions that are similar to those found in the federal False Claims Act. It has, however, adopted “vendor fraud” and false statement statutes that make it unlawful for a person to, among other things, submit false claims to the Connecticut Medicaid program or to accept excessive payments for goods or services performed. Violations of these statutes are criminal offenses and are punishable by imprisonment and significant fines. Conn. Gen. Stat. §§ 53a-290 et seq., 17B-238. In certain circumstances, individuals who report fraud may be eligible for up to 15% of the amounts recovered attributable to the report. Regs. Conn. Stage Agencies §§ 17b-102-01 et seq.
DELAWARE

The Delaware False Claims and Reporting Act (“FCRA”) helps the state government combat fraud and recover losses resulting from fraud in state programs, purchases, or contracts. Del Code Ann. Tit. 6, §§ 1201–1209.

Liability and Damages/Statute of Limitations

- The actions that violate the FCRA include: (1) submitting a false claim for payment, (2) making or using a false record to get a false claim paid, (3) conspiring to make a false claim or get one paid, or (4) making or using a false record to avoid payments owed to the state government.

- Penalties of $5,500 to $11,000 per claim plus three times the amount of damages to the state or county for FCRA violations may be imposed.

- A civil suit must be filed within the latter of: (1) six years after the violation was committed or (2) three years after the date that the violation was discovered (but no more than ten years after the violation was committed).

Qui Tam Actions/Whistleblower Protections

- An individual (or *qui tam* plaintiff) can sue for violations of the FCRA. Individuals who report fraud receive between 15 and 25 percent of the total amount recovered if the government prosecutes the case, and between 25 and 30 percent (plus reasonable costs and attorney fees) if the *qui tam* plaintiff litigates the case on his or her own. An individual cannot file a lawsuit based on public information, unless he or she is the original source of the information.

- The FCRA contains important protections for whistleblowers. Employees who report fraud and consequently suffer discrimination may be awarded (1) two times their back pay plus interest, (2) reinstatement at the seniority level they would have had but for the discrimination, and (3) compensation for any costs or damages they have incurred.
FLORIDA

The Florida False Claims Act (“FFCA”) helps prevent fraud and allows the state to recover funds lost because of fraud in state programs, purchases, or contracts. Fla. Stat. §§ 68.081–68.09.

Liability and Damages/Statute of Limitations

• The actions that violate the FFCA include: (1) submitting a false claim for payment, (2) making or using a false record to get a false claim paid, (3) conspiring to make a false claim or get one paid, or (4) making or using a false record to avoid payments owed to the state government.

• Penalties of $5,000 to $10,000 per claim plus three times the amount of damages to the state government for FFCA violations may be imposed.

• Lawsuits must be filed within the latter of either: (1) five years after the violation was committed, or (2) two years after the state official responsible for investigating the violation discovered the important facts (but no more than seven years after the violation was committed).

Qui Tam Actions/Whistleblower Provisions

• An individual (or *qui tam* plaintiff) can sue for violations of the FFCA. Individuals who report fraud receive between 15 and 25 percent of the total amount recovered if the state prosecutes the case, and between 25 and 30 percent (plus reasonable costs and attorney fees) if the *qui tam* plaintiff litigates the case on his or her own. An individual cannot file a lawsuit based on public information, unless he or she is the original source of the information.

• Employees who report fraud and consequently suffer discrimination can sue their employers under the Florida Civil Rights Act.
GEORGIA

The state of Georgia has not adopted any false claims acts or statutes that contain qui tam or whistleblower provisions that are similar to those found in the federal False Claims Act. It has, however, adopted a Medicaid anti-fraud statute that makes it unlawful for a person to submit false and fraudulent claims to the Georgia Medicaid program. Violations of the statute are civil and criminal offenses and are punishable by imprisonment and significant fines and monetary penalties. See Ga. Code Ann. §§ 49-4-146.1, 16-10-20, and 16-10-21.
HAWAII


Liability and Damages/Statute of Limitations

- The actions that violate the HFCA include: (1) submitting a false claim for payment, (2) making or using a false record to get a false claim paid, (3) conspiring to make a false claim or get one paid, or (4) making or using a false record to avoid payments owed to the state government. In addition, anyone who benefits from a false claim that was mistakenly submitted violates the HFCA if he or she does not disclose the false claim soon after he or she discovers it.

- Penalties of $5,000 to $10,000 per claim plus three times the amount of damages to the state or county for HFCA violations may be imposed.

- A civil suit must be filed within six years after the violation was discovered, but no more than ten years after the violation was committed.

Qui Tam Actions

- An individual (or qui tam plaintiff) can sue for violations of the HFCA. Individuals who report fraud receive between 15 and 25 percent of the total amount recovered if the government prosecutes the case, and between 25 and 30 percent (plus reasonable costs and attorney fees) if the qui tam plaintiff litigates the case on his or her own. An individual cannot file a lawsuit based on public information, unless he or she is the original source of the information.

- The HFCA contains no special protections for whistleblowers.

County False Claims Law
The county false claims law is virtually identical to that of the state false claims law, except that its provisions reflect the fact that the government is a county.
ILLINOIS


Liability and Damages/Statute of Limitations

- Actions that violate the WRPA include: (1) submitting a false claim for payment, (2) making or using a false record to get a false claim paid, (3) conspiring to make a false claim or get one paid, or (4) making or using a false record to avoid payments owed to the State.

- Penalties of $5,000 to $10,000 per claim plus three times the amount of damages to the state government for WRPA violations may be imposed.

- Lawsuits must be filed within the latter of either: (1) three years after the violation is discovered by the State official responsible for investigating violations (but no more than ten years after the violation was committed), or (2) six years after the violation was committed.

Qui Tam Actions/Whistleblower Provisions

- An individual (or qui tam plaintiff) can sue for violations of the WRPA. Individuals who report fraud receive between 15 and 25 percent of the total amount recovered if the State prosecutes the case, and between 25 and 30 percent (plus reasonable costs and attorney fees) if the qui tam plaintiff litigates the case on his or her own. An individual cannot file a lawsuit based on public information, unless he or she is the original source of the information.

- The WRPA contains important protections for whistleblowers. Employees who report fraud and consequently suffer discrimination may be awarded (1) two times their back pay plus interest, (2) reinstatement at the seniority level they would have had but for the discrimination, and (3) compensation for any costs or damages incurred.
INDIANA

The Indiana False Claims Act (“IFCA”) helps the state combat fraud and recover losses resulting from fraud in programs, purchases, or contracts. Ind. Code Ann. §§ 5-11-5.5-5.

Liability and Damages/Statute of Limitations

- Actions that violate the IFCA include: (1) submitting a false claim for payment, (2) making or using a false record to get a false claim paid, (3) conspiring with another person to make a false claim or get one paid, or (4) making or using a false record to avoid payments owed to the governmental entity.

- The minimum civil penalty is $5,000 per claim. Damages of up to three times the amount that the state sustains because of the violation may also be awarded. The courts will waive penalties for IFCA violations and reduce damages if the false claims are voluntarily disclosed.

- A civil suit must be filed within six years after the date that the violation was discovered, but no more than ten years after the violation was committed.

Qui Tam Actions/Whistleblower Protections

- A private person (or qui tam plaintiff) can sue for violations of the IFCA. Individuals who report fraud receive between 10 and 15 percent of the total amount recovered if the state prosecutes the case, and between 25 and 30 percent (plus reasonable costs and attorney fees) if the private person litigates the case on his or her own as a qui tam action. An individual cannot file a lawsuit based on public information, unless he or she is the original source of the information.

- The IFCA contains protections for whistleblowers. Employees who suffer discrimination due to their disclosure of fraudulent activity 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.
IOWA

The state of Iowa has not adopted any false claims acts or statutes at this time.
KANSAS

The state of Kansas has not adopted any false claims acts or statutes that contain qui tam or whistleblower provisions that are similar to those found in the federal False Claims Act. It has, however, adopted a Medicaid Fraud Control Act that makes it unlawful for a person to submit false and fraudulent claims to the Kansas Medicaid program. Violation of this Act is a criminal offense punishable by substantial fines and imprisonment. Additionally, violators of the Act may be liable for payment of full restitution to the state plus interest and reasonable expenses. Kan. Stat. Ann. §§ 21-3844 et seq.
KENTUCKY

Kentucky has not adopted any false claims acts or statutes that contain *qui tam* provisions that are similar to those found in the federal False Claims Act. It has, however, adopted a generally applicable Medicaid anti-fraud statute that makes it unlawful for a person to submit false and fraudulent claims to the Kentucky Medicaid program. The statute also makes it unlawful for any person to present false information regarding an institution or facility so that it may be licensed or recertified as a Medicaid provider. Violations of the statute are both civil and criminal offenses and are punishable by substantial fines and imprisonment. Ky. Rev. Stat. Ann. §§ 205.8451, 205.8463, 205.8465, 205.8467. Any person who reports suspected fraud to the state Medicaid Fraud Control Unit or the Medicaid Fraud and Abuse hotline shall not be liable in any civil or criminal action based on the report if it was made in good faith, nor may an employer, without just cause, discharge or in any manner discriminate or retaliate against any person who in good faith makes such a report or who participates in any proceeding related to such report. Ky. Rev. Stat. Ann. § 205.8465.

**Liability and Damages/Statute of Limitations**

- Actions that violate the MAPIL are knowingly submitting false claims for payment from medical assistance programs, including claims for medically unnecessary or substandard services. The MAPIL also addresses false illegal kickbacks of patient referrals, the delivery of substandard goods and services, and false representations of Medicaid eligibility.

- Penalties of up to $10,000 per claim may be imposed, plus three times the amount of damages to the state government for false claim violations. The court can waive penalties and limit recovery to actual damages if the defendant voluntarily discloses violations and cooperates with the investigation.

- A civil suit must be filed within ten years after the violation was committed.

**Qui Tam Actions/Whistleblower Provisions**

- A private individual (or *qui tam* plaintiff) can sue for violations of the MAPIL, but only the state can seek civil monetary penalties. *Qui tam* plaintiffs who report fraud receive between 10 and 20 percent of the total amount recovered if the state prosecutes the case, and up to 30 percent (plus reasonable costs and attorney fees) if the *qui tam* plaintiff litigates the case on his or her own. A *qui tam* plaintiff cannot file a lawsuit based on public information, unless he or she can confirm that he or she is the original source of the information.

- The MAPIL contains important protections for whistleblowers. Employees who suffer discrimination because of their involvement in false claims actions may be awarded full relief plus punitive damages from their employers.
MAINE

The state of Maine has not adopted any false claims acts or statutes that contain *qui tam* or whistleblower provisions that are similar to those found in the federal False Claims Act. It has, however, adopted a false claims statute that makes it unlawful for any person to make, or cause to be made, or presented or cause to be presented for payment, any claim to the Medicaid program, knowing such claim to be false, fictitious or fraudulent, or to aid or abet in any such conduct. Violations of this statute are criminal and civil offenses and are punishable by imprisonment and/or significant monetary penalties. 22 MRSA § 15. In addition, the state has enacted a general whistleblower protection act that makes it unlawful to retaliate in any fashion against an individual, who, acting in good faith, reports orally or in writing to the employer or a public body that the employee has reasonable cause to believe there is a violation of law or rule adopted by the state. 26 MRSA § 831 et. seq.
MARYLAND

The state of Maryland has not adopted any false claims acts or statutes that contain qui tam or whistleblower provisions that are similar to those found in the federal False Claims Act. It has, however, adopted a Medicaid fraud statute that makes it unlawful for a person to submit false and fraudulent claims to the state health plan. Violation of this statute is a criminal and civil offense punishable by substantial fines and imprisonment. See Md. Code Ann. § 8-509 et seq.

No state false claims act exists at this time.
The Massachusetts False Claims Act (“MFCA”) is a law designed to help the state government combat fraud and recover losses resulting from fraud in state programs, purchases, or contracts. Mass. Gen. Laws Ann. ch. 12, § 5.

**Liability and Damages/Statute of Limitations**

- Actions that violate the MFCA include: (1) submitting a false claim for payment, (2) making or using a false record to get a false claim paid, (3) conspiring to make a false claim or get one paid, or (4) making or using a false record to avoid payments owed to the Commonwealth or a political subdivision. Anyone who enters into an agreement or contract with the Commonwealth or a political subdivision, knowing that the information contained therein is false violates the MFCA. In addition, anyone who benefits from a false claim that was mistakenly submitted violates the MFCA if he or she does not disclose the false claim within a reasonable time after he or she discovers it. Contracts are also subject to the MFCA.

- Penalties of $5,000 to $10,000 per claim may be imposed, plus three times the amount of damages to the Commonwealth or political subdivision for MFCA violations.

- A civil suit must be filed within the latter of: (1) six years after the violation was committed, or (2) three years after the date that the violation was discovered (but no more than ten years after the violation was committed).

**Qui Tam Actions/Whistleblower Protections**

- An individual (or *qui tam* plaintiff) can sue for violations of the MFCA. Individuals who report fraud receive between 15 and 25 percent of the total amount recovered if the government prosecutes the case, and between 25 and 30 percent (plus reasonable costs and attorney fees) if the *qui tam* plaintiff litigates the case on his or her own. An individual cannot file a lawsuit based on public information, unless he or she is the original source of the information.

- The MFCA contains important protections for whistleblower. Employees who report fraud and consequently suffer discrimination may be awarded (1) two times their back pay plus interest, (2) reinstatement at the seniority level they would have had but for the discrimination, and (3) compensation for any costs or damages they have incurred.
MICHIGAN

The Michigan Medicaid False Claims Act (“MMFCA”) is a state law that is designed prevent fraud, kickbacks, and conspiracies in connection with the Medical Assistance Program. Mich. Comp. Laws Ann. §§ 400.601-400.613.

Liability and Damages/Statute of Limitations

- Actions that violate the MMFCA include: (1) knowingly making (or causing to be made) a false statement in an application for benefits or for use in determining Medicaid eligibility; (2) concealing or failing to disclose an event in order to obtain a benefit greater than that to which the person is otherwise entitled; and (3) conspiring to defraud the state by obtaining (or seeking to obtain) payment of a false claim. Violations are punishable by civil and criminal penalties.

- Violation of the MMFCA constitutes a felony punishable by four years or less in prison, or a fine of $50,000 or less, or both. A person who receives a benefit to which he or she is not entitled, by reason of fraud; makes a fraudulent statement; or knowingly conceals a material fact is liable to the state for a civil penalty equal to the full amount received plus triple damages.

Qui Tam Actions/Whistleblower Protections

- An individual (or qui tam plaintiff) can sue for violations of the MMFCA. Individuals who report fraud receive between 15 and 25 percent of the total amount recovered if the government prosecutes the case and between 25 and 30 percent if the qui tam plaintiff litigates the case on his or her own. An individual cannot file a lawsuit based on public information, unless he or she is the original source of the information.

- The MMFCA contains important protections for whistleblowers. Employees who report fraud and consequently suffer discrimination may be awarded (1) two times their back pay plus interest, (2) reinstatement in their position without loss of seniority, and (3) compensation for any costs or damages they have incurred.
MINNESOTA

The state of Minnesota has not adopted any false claims acts or statutes that contain qui tam or whistleblower provisions that are similar to those found in the federal False Claims Act. It has, however, adopted Medicaid fraud and false statements statutes that make it unlawful for a person to submit false and fraudulent claims to the state. Violations of these statutes are civil and criminal offenses punishable by substantial fines and imprisonment. See Minn. Stat. §§ 609.466, 609.52, 256B.064, 256B.121.
MISSOURI

The state of Missouri has not adopted any false claims acts or statutes that contain qui tam or whistleblower provisions that are similar to those found in the federal False Claims Act. It has, however, adopted false statement statutes that make it unlawful for a person to submit false and fraudulent claims to the Missouri Medicaid program. Violations of these statutes are criminal and civil offenses punishable by substantial fines and imprisonment. Additionally, violators may be liable for payment of full restitution to the state plus interest and reasonable expenses. See Mo. Rev. Stat. § 191.900 et seq., 198.006, 198.142, 198.155, 198.158.
MISSISSIPPI

Mississippi has not adopted any false claims acts or statutes that contain *qui tam* provisions that are similar to those found in the federal False Claims Act. It has, however, adopted a generally applicable Medicaid Fraud Control Act that makes it unlawful for a person to submit false and fraudulent claims to the Mississippi Medicaid program. Violations of the Act are both civil and criminal offenses and are punishable by imprisonment and significant monetary penalties. Miss. Code Ann. §§ 43-13-209, 43-13-211, 43-13-213, 43-13-215, & 43-13-225.
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 Attorney General. (Neb. Rev. Stat. Ann.. §§ 68-934 et seq.).

Violations of the FMCA include: (1) knowingly presenting (or causing to be presented) a false claim, (2) knowingly making or using (or causing to be made or used) a false record or statement to obtain payment or approval of a false claim, (3) conspiring to defraud the state by obtaining payment or approval of a false claim, (4) possessing property or money used by the state and intending to defraud the state or willfully concealing the property, delivering (or causing to be delivered) less than the amount for which a person has received a certificate or receipt, (5) buying or receiving public property from any officer or employee of the state knowing that he or she may not lawfully sell or pledge the property, and (6) knowingly making or using (or causing to be made or used) a false record or statement with the intent to conceal, avoid, or decrease an obligation 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.

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.

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, (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 if the false claims are voluntarily disclosed.
NEVADA


Liability and Damages/Statute of Limitations

- Actions that violate the SFC include: (1) submitting a false claim for payment, (2) making or using a false record to get a false claim paid, (3) conspiring to make a false claim or get one paid, or (4) making or using a false record to avoid payments owed to the state or local government. In addition, anyone who benefits from a false claim that was mistakenly submitted violates the SFC if he or she does not disclose the false claim soon after he or she discovers it.

- Penalties of $2,000 to $10,000 per claim plus three times the amount of damages to the state government for false claim violations may be imposed.

- A civil suit must be filed within the latter of three years after the violation is discovered by the Attorney General or within five years after the violation is committed.

Qui Tam Actions/Whistleblower Provisions

- Individuals (or qui tam plaintiffs) can sue for violations of the statute. Qui tam plaintiffs who report fraud receive between 15 and 33 percent of the amount recovered in cases where the state prosecutes the case, and between 25 and 50 percent (plus reasonable costs and attorney fees) in cases where the qui tam plaintiff litigates the case on his or her own. A qui tam plaintiff cannot file a lawsuit based on public information, unless he or she is the original source of the information.

- The SFC bars employers from interfering with an employee’s disclosure of false claims. Employees who report fraud and consequently suffer discrimination 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, (3) compensation for any costs or damages they have incurred, and (4) punitive damages, if appropriate.

Liability and Damages

- Actions that violate the NHFCA include: (1) submitting a false claim for payment, (2) making or using a false record to get a false claim paid, (3) conspiring to make a false claim or get one paid, or (4) making or using a false record to avoid payments owed to the state or local government. In addition, anyone who benefits from a false claim that was mistakenly submitted violates the NHFCA if he or she does not disclose the false claim soon after he or she discovers it.

- Penalties of $5,000 to $10,000 per claim may be imposed, plus three times the amount of damages to the state or county.

- Claims must be filed within the latter of six years after the violation was committed or three years after the violation is discovered (but not more than ten years) after the violation was committed.

Qui Tam Actions/Whistleblower Protections

- Private individuals (or qui tam plaintiffs) who report fraud receive between 15 and 25 percent of the total amount recovered if the attorney general prosecutes the case. An individual cannot file a lawsuit based on public information unless he or she is the original source of the information.

- The NHFCA contains important protections for whistleblowers. Employees who report fraud and consequently suffer discrimination may be awarded (1) two times their back pay plus interest, (2) reinstatement at the seniority level they would have had but for the discrimination, and (3) compensation for any costs or damages incurred.
NEW JERSEY

The state of New Jersey has not adopted any false claims acts or statutes that contain qui tam or whistleblower provisions that are similar to those found in the federal False Claims Act. It has, however, adopted health care fraud statutes that make it unlawful for a person to submit false and fraudulent claims to the New Jersey Medical Assistance Program or otherwise commit health care fraud. Violations of these statutes are criminal and civil offense punishable by substantial fines and imprisonment. N.J. Stat. Ann. §§ 30:4D-17, 2C:21-4.2, 2C:21-4.3.
NEW MEXICO


Liability and Damages

- Actions that violate the NMFCA include: (1) submitting a false claim for payment under the Medicaid program, (2) submitting a claim for payment under the Medicaid program knowing that the person receiving the benefit is not eligible; (3) making a false record or statement to get a false claim paid; (4) conspiring to defraud the state by getting a false claim paid; and (5) making a claim under the Medicaid program for a service or product that was not provided. It is also a violation to make a false statement or misrepresentation concerning the conditions or operation of a health care facility so that the facility may qualify for certification or recertification by the Medicaid program.

- Any person or entity that violates the NMFCA is liable for three times the amount of damages that the state sustains.

- Actions must be filed within four years after the claim was submitted.

Qui Tam Actions/Whistleblower Protections

- Private individuals (or qui tam plaintiffs) who report fraud receive between 10 and 25 percent of the total amount recovered if the human services department prosecutes the case, and between 25 and 30 percent (plus reasonable costs and attorney fees) if the qui tam plaintiff litigates the case on his or her own. An individual cannot file a lawsuit based on public information, unless he or she is the original source of the information. The NMFCA contains important protections for whistleblowers.

- Employees who report fraud and consequently suffer discrimination 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.
NEW YORK

The state of New York has not adopted any false claims acts or statutes that contain *qui tam* or whistleblower provisions that are similar to those found in the federal False Claims Act. It has, however, adopted a Medicaid anti-fraud statute that makes it unlawful for a person to submit false and fraudulent claims to the New York Medicaid program. Violations of the statute are criminal and civil offenses punishable by imprisonment and/or significant monetary penalties. See McKinney’s Social Services Law, § 145-b.
NORTH CAROLINA

The state of North Carolina has not adopted any false claims acts or statutes that contain qui tam or whistleblower provisions that are similar to those found in the federal False Claims Act. It has, however, adopted a Medical Assistance Provider False Claims Act (“MAPFCA”) and a medical provider fraud statute that make it unlawful for a person to submit false and fraudulent claims to the North Carolina medical assistance program. See N.C. Gen. Stat. §§ 108A-70.10 et seq., 108A-63, 108A-64. Violations of these statutes are criminal and civil offenses punishable by substantial fines and imprisonment. Additionally, violators of the MAPFCA may be liable for payment of full restitution to the state plus interest and reasonable expenses. Employees who are discriminated against by their employers because of lawful acts done in the furtherance of an action under the MAPFCA are entitled to all relief necessary to be made whole. N.C. Gen. Sta. § 108A-70.15.
OHIO

At this time, there is no Ohio false claims act that closely parallels the federal False Claims Act. However, Ohio law requires that certain health care entities provide certain information about the federal False Claims Act and Ohio false statement laws and whistleblower protections. (Ohio Rev. Code Ann. § 5111.101).

Section 2913.40 of the Ohio Revised Code is a criminal law statute that is designed to prevent the commission of fraud on the state medical assistance program. (Ohio Rev. Code Ann. § 2913.40). 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).

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, state employees in classified or unclassified civil service who become aware of violations of state or federal laws may file a written report with their supervisor (if such supervisor has the authority to correct the violation). If the state employee reasonably believes that the violation is a criminal offense, the employee may report it to, among other persons, a prosecuting attorney, chief legal officer of a municipal organization, peace officer, or inspector general, as applicable. (Ohio Rev. Code Ann. § 124.341).

Ohio law also provides protections for state employees. No state officer or state employee shall take any disciplinary action against a state employee for reporting any violations of state or federal law under Section 124.341, provided that the information in the report was not knowingly or recklessly false. “Disciplinary action” includes (1) the removal or suspension of the employee from employment, (2) the withholding of salary increases or employee benefits to which the employee is otherwise entitled, (3) transferring or reassigning the employee, (4) denying the employee promotion that otherwise would have been received, and (5) the reduction in the employee’s pay or position. If disciplinary action is taken against the employee, the employee may file an appeal with the state personnel board within thirty days after receiving actual notice of the appointing authority’s action.

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.
Oklahoma has not adopted any false claims acts or statutes that contain *qui tam* provisions that are similar to those found in the federal False Claims Act. It has, however, adopted a generally applicable Medicaid anti-fraud statute that makes it unlawful for a person to submit false and fraudulent claims to the Oklahoma Medicaid program. Violations of the statute are both civil and criminal offenses and are punishable by imprisonment and significant monetary penalties. Okla. Stat. tit. 56, §§ 1005-1007; Okla. Stat. tit. 21, §§ 358-359.
PENNSYLVANIA

Pennsylvania has not adopted any false claims acts or statutes that contain *qui tam* provisions that are similar to those found in the federal False Claims Act. It has, however, adopted a fraud and abuse statute that makes it unlawful for a person to submit false or fraudulent claims to the Pennsylvania medical assistance program. Violations of this statute are criminal and civil offenses punishable by imprisonment and substantial fines and monetary penalties. Pa. Stat. Ann. tit. 62 § 1407.
SOUTH CAROLINA

South Carolina has not adopted any false claims acts or statutes that contain *qui tam* provisions that are similar to those found in the federal False Claims Act. It has, however, adopted a generally applicable Medicaid anti-fraud statute that makes it unlawful for a person to submit false and fraudulent claims to the South Carolina Medicaid program. Violations of the statute are both civil and criminal offenses and are punishable by imprisonment and significant monetary penalties. S.C. Code Ann. § 43-7-60; S.C. Code Regs. 126-403
The Tennessee False Claims Act ("TFCA") is a state law that is designed to help the state government and political subdivisions combat fraud and recover losses resulting from fraud in programs, purchases, or contracts. Tenn. Code Ann. §§ 4-18-101. The Tennessee Medicaid False Claims Act ("TMFCA") applies solely to false claims under the Medicaid program. Tenn. Code Ann. §§ 71-5-182.

**Liability and Damages/Statute of Limitations**

- Actions that violate the both the TFCA and the TMFCA include: (1) submitting a false claim for payment, (2) making or using a false record to get a false claim paid, (3) conspiring to make a false claim or get one paid, or (4) making or using a false record to avoid payments owed. In addition, anyone who benefits from a false claim that was mistakenly submitted also violates the TFCA if he or she does not disclose the false claim soon after he or she discovers it. Finally, the TFCA also broadly prohibits using any false representation or practice to procure anything of value from the state government or any political subdivision. The courts can waive penalties and reduce damages for violations if the false claims are voluntarily disclosed. The TFCA does not apply to controversies of less than $500, workers’ compensation claims, Medicaid claims, or tax claims.

- Penalties of $2,500 to $10,000 per claim plus three times the amount of damages to the state or political subdivision may be imposed for TFCA violations.

- Under the TFCA, a civil suit must be filed within three years after the violation was discovered, but no more than ten years after the violation was committed.

- The TMFCA applies only to Medicaid claims. Penalties of $5,000 to $10,000 per claim plus treble damages may be imposed for TMFCA violations.

- Under the TMFCA, a civil suit can be filed within the later of: (1) six years after the violation was committed, or (2) three years after the violation was discovered (but no more than ten years after the violation was committed).

**Qui Tam Actions/Whistleblower Protections**

- An individual (or *qui tam* plaintiff) can sue for violations of the TFCA or the TMFCA. Individuals who report fraud receive between 25 and 33 percent of the total amount recovered if the government prosecutes the case under the TFCA and between 15 and 25 percent under the TMFCA. If the *qui tam* plaintiff litigates the case on his or her own, he
or she receives between 33 and 50 percent of the proceeds under the TFCA and between 25 and 30 percent under the TMFCA (plus reasonable costs and attorney fees). Under both acts, an individual cannot file a lawsuit based on public information, unless he or she is the original source of the information.

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

**Liability and Damages**

- Actions that violate the FPL include: (1) making a false statement or concealing information that affects the right to a Medicaid benefit or payment, (2) submitting a claim for Medicaid payment for a product or service rendered by a person who is not licensed to provide that product or service or fails to indicate the license of the practitioner who actually performed the service, (3) submitting a claim for a service or product that has not been approved by the treating health care practitioner, or (4) conspiring to defraud the state by obtaining an unauthorized payment from the Medicaid program or its fiscal agent.

- The law requires restitution of the value of any Medicaid payment plus interest, damages of two times the value of the payment, and a civil penalty of $5,000 to $15,000 for each violation that results in an injury to a disabled person, an elderly person, or a person younger than 18 years of age. If the violation does not result in such an injury, the law requires a civil penalty of $1,000 to $10,000 for each violation and damages of two times the value of the payment. A court may waive the civil penalties and award two times the amount of the payment if the defendant voluntarily discloses the violations.

**Whistleblower Provisions**

- Private individuals who report fraud receive between 10 and 25 percent of the total amount recovered if the state prosecutes the case. A private individual cannot prosecute a case on his or her own. The FPL contains important protections for whistleblowers.

- Employees who suffer discrimination because of their involvement in false claims actions may be awarded (1) two times their back pay plus interest, (2) reinstatement at the seniority level they would have had but for the discrimination, and (3) compensation for any costs or damages they have incurred.
VIRGINIA

The Virginia Fraud Against Taxpayers Act (“FTA”) is a state law that helps the Commonwealth combat fraud and recover losses resulting from fraud in programs, purchases, or contracts. Va. Code Ann. §§ 8.01-216.1.

Liability and Damages/Statute of Limitations

- Actions that violate the FTA include: (1) submitting a false claim for payment, (2) making or using a false record to get a false claim paid, (3) conspiring to make a false claim or get one paid, or (4) making or using a false record to avoid payments owed to the Commonwealth or a political subdivision.

- The Commonwealth imposes penalties of $5,500 to $10,000 per claim, three times the amount of damages to the Commonwealth for FTA violations, plus the costs of a civil suit for recovery of penalties or damages.

- A civil suit must be filed within the latter of: (1) six year after the violation was committed, or (2) three years after the date that the violation was discovered (but no more than ten years after the violation was committed).

Qui Tam Actions/Whistleblower Protections

- An individual (or qui tam plaintiff) can sue for violations of the FTA. Individuals who report fraud receive between 15 and 25 percent of the total amount recovered if the government prosecutes the case, and between 25 and 30 percent (plus reasonable costs and attorney fees) if the qui tam plaintiff litigates the case on his or her own. An individual cannot file a lawsuit based on public information, unless he or she is the original source of the information. The FTA contains important protections for whistleblower.

- Employees who report fraud and consequently suffer discrimination 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.
WASHINGTON

What is the Washington False Claims Act?

The Washington Health Care False Claim Act ("HC FCA") is a state law directed at eliminating the costs of fraudulent health care claims by establishing specific penalties and deterrents. (Rev. Code Wash. §§ 48.80.010 – 48.80.900).

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

What are the Qui Tam Provisions and Whistleblower Protections?
The HC FCA 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?
Violators of the HC FCA 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 HC FCA does not preclude action under any other applicable state law.

The HC FCA 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.
WEST VIRGINIA

West Virginia has not adopted any false claims acts or statutes that contain *qui tam* provisions that are similar to those found in the federal False Claims Act. It has, however, adopted a generally applicable Medicaid Fraud Control Act that makes it unlawful for a person to submit false and fraudulent claims to the West Virginia Medicaid program. Violations of the Act are both civil and criminal offenses and are punishable by imprisonment and significant monetary penalties. W. Va. Code Ann. § 9-7-4.
WISCONSIN

Wisconsin has not adopted any false claims acts or statutes that contain *qui tam* provisions that are similar to those found in the federal False Claims Act. It has, however, adopted a generally applicable Medicaid fraud anti-fraud statute that makes it unlawful for a person to submit false and fraudulent claims to the Wisconsin Medicaid program. Violations of the Act are both civil and criminal offenses and are punishable by imprisonment and significant monetary penalties. See § 49.49(1), Wis. Stats.