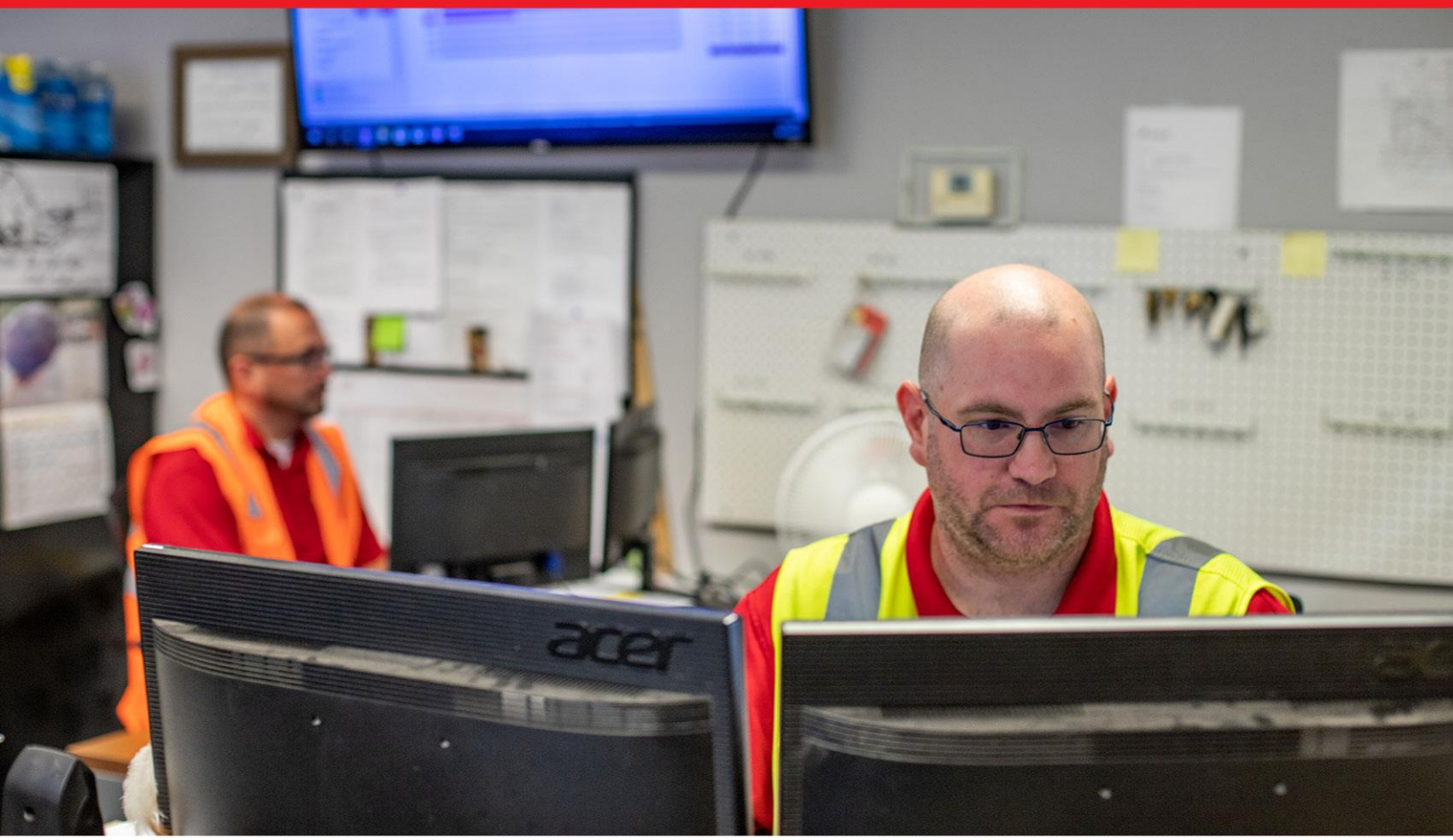

Healthcare Fraud, Waste and Abuse Policy

transdev
the mobility company

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Note

Transdev acquired the stock of First Transit, Inc. and the closing took place on March 6, 2023. First Transit, Inc. will continue to operate as its own, stand-alone legal entity as a wholly-owned subsidiary of Transdev North America, Inc. There is no change in the legal status of either company. As such, while the Transdev brand will be more visible going forward, no contractual assignments are required for any existing Transdev contracts.

This document has been updated to reflect the Transdev name and brand. Physical and web addresses, as well as contact names and details have also been updated where necessary.

Rest assured, Transdev's rebranding efforts will have no impact on and in no way effect how First Transit currently operates, the legal status First Transit, Inc., or the contractual relationships between First Transit, Inc. and our clients with whom they contract.

Document Information

Original date of issue	December 2013
Filename	Healthcare FWA Policy
Date of last review	December 2023
Business Owner	Legal/Compliance
Authorized by	Transdev Compliance Director

Definitions

1. Introduction

1.1. As a provider of certain healthcare items and services under federal healthcare programs and the various state Medicaid Programs, Transdev is committed to operating in an honest and ethical manner and complying with applicable laws, regulations and any other Group policies or requirements. This commitment requires that our employees and all those we engage with in business act with honesty and integrity. Our standards are set out in Transdev's Compliance Program, Group's Code of Business Ethics and Anti-Fraud Policy and other policies referenced herein.

1.2. This Fraud, Waste and Abuse Policy is one of a number of policies which support the Group's Code of Business Ethics and it provides specific guidance regarding the standards which we are required to uphold in connection with detecting, correcting, and preventing fraud, waste, and abuse. Among other things, this policy describes the steps we will take to prevent the occurrence of fraud, waste and abuse and the actions we will take if our standards are not met.

1.3. We have zero tolerance for the commission or concealment of acts of fraud, waste or abuse, and such acts will not be tolerated by Transdev or the Group.

1.4. The overwhelming majority of our employees conduct themselves professionally and fully in accordance with the Group Code of Business Ethics and Transdev's Compliance Program. We also recognize, however that as in all businesses, fraud, waste or abuse may occur. In these circumstances it is appropriate to have a Fraud, Waste and Abuse Policy.

This Policy provides clear guidance on the:

1.4.1 Definition of fraud, waste and abuse.

1.4.2 Scope of the policy (who it applies to)

1.4.3 Standards required (of employees and others with whom the business engages, such as contractors or other third parties)

1.4.4 Federal and state laws regulating fraud, waste and abuse

1.4.5 Measures in place to detect and prevent fraud, waste and abuse

1.4.6 Procedures in place for reporting fraud, waste and abuse

1.4.7 Procedures in place for investigating allegations of fraud, waste and abuse

1.4.8 Actions which will follow any breach (of this policy)

2. Definitions

2.1. Fraud is any intentional act of dishonesty, misconduct, deception, false representation or omission in order to gain a material advantage or to harm the interests of others. Fraud includes intentionally making, or attempting to make, a false claim, representation, or promise in an effort to receive payment or property to which one is not entitled.

2.2. Fraud in the healthcare industry may involve:

2.2.1 Billing for services that weren't ordered or provided

2.2.2 Billing more than once for the same service

2.2.3 Intentionally using improper coding to receive a higher rate of reimbursement

2.2.4 Identity theft, resulting in claims submitted for non-covered persons

2.2.5 Kickbacks in exchange for referrals or additional business

2.2.6 Alteration of records to get services covered

2.2.7 Billing for transportation services nonmedical locations

2.2.8 Falsifying driver or vehicle documentation

2.3. Waste is the overutilization of services or other practices resulting primarily from mismanagement, inappropriate actions or inadequate oversight.

Waste frequently results in:

2.3.1 Unnecessary costs to the health care system

2.3.2 Improper payment for services

2.3.3 Payment for services that fail to meet professionally recognized standards of care

2.3.4 Services which are medically unnecessary

2.4. **Abuse** involves practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to a healthcare program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. Abuse involves payment for items or services when there is no legal entitlement to that payment and a healthcare provider has not knowingly and/or intentionally misrepresented facts to obtain payment.

2.5. Examples of abuse may include:

2.5.1 Charging in excess for services

2.5.2 Billing for items or services that should not have been provided

3. Scope of Policy

3.1. This Policy communicates our strong and explicit organizational commitment to conducting business ethically, with integrity and in compliance with applicable laws, regulations and requirements. This Policy extends to any act of fraud, waste and abuse committed within the business.

3.2. This Policy directly applies to all Transdev employees at or supporting Transdev location that provides healthcare items or services billable under federal or state healthcare programs, including Medicaid programs. Such locations are deemed “Healthcare Locations” for purposes of this Policy.

3.3. We also require our business partners to uphold a similar commitment to ethical conduct and assure that they, their employees, and downstream entities who support our business also comply with the guiding principles outlined within this policy. As such, the principles in this policy will also be applied to any third parties who defraud or attempt to defraud our business or defraud

others while acting on our behalf, or otherwise engaging in business with Transdev, such as contractors, suppliers, customers or those independent of our business operations.

4. Standards

4.1. All employees are expected to conduct themselves in accordance with Group Code of Business Ethics and, in particular, to adhere at all times to this Policy.

4.2. In addition, all employees are required to conduct themselves in accordance with any additional policies or obligations set forth in our Transdev Compliance Program (the "Transit Compliance Program").

4.3. Employees are expected to carry out their duties with honesty and integrity, not to engage in any conduct which may constitute fraud, waste and abuse. As part of their obligations under this Policy, we expect our employees to cooperate fully with any investigation into fraud, waste and abuse.

4.4. The standards of conduct set forth in this Policy are also the expectations we have for third parties acting on our behalf, or otherwise engaging in business with Transdev (such as contractors and suppliers).

4.5. This Policy also requires anyone who has any information or a suspicion that fraud, waste or abuse is occurring or has occurred within the business to report it in accordance with the procedures set out in this Policy and Group's Anti-fraud Policy. See Section 7.0, How to Report Fraud, Waste and Abuse below.

5. Laws Pertaining to Fraud, Waste and Abuse

5.1. Federal False Claims Act 31 U.S.C. §§ 3729 - 3733

The federal False Claims Act (FCA) prohibits any person or entity from knowingly submitting, causing to be submitted or presenting a false claim to any federal employee or agency for payment or approval, such as a claim for reimbursement from Medicare or Medicaid. The FCA also prohibits any person or entity from knowingly making or using a false record or statement to obtain approval of a claim for reimbursement. Examples of false claims may include:

- Billing for services not provided;
- Billing for mileage when a patient was not in the vehicle;
- Billing for services that are not documented;
- Falsifying a driver's qualifications on the driver's record;
- Billing for transportation to a non-medical destination, such as a grocery store;
- Submitting duplicate claims for the same service;
- Inaccurate or incorrect coding of the services provided;
- Failing to report overpayments or credit balances; or
- Participating in violations of the Anti-Kickback Law.

"Knowingly" means a person has actual knowledge of the information, acts in deliberate ignorance

of the truth or falsity of the information, or acts in reckless disregard of the truth or falsity of the information. A violation of the FCA does not require proof of a specific intent to defraud.

A "claim" includes any request or demand for money or property to the federal government or to a federal contractor, grantee or other recipient, if any portion of the requested money or property is funded by or will be reimbursed by the federal government, such as the Medicaid program.

A person or entity that violates the FCA will be subject to the following:

- Civil monetary penalties ranging from $11,000.00 to $21,563.00 for each false claim submitted;
- A fine of 3 times the amount of the damages sustained by the federal government; and
- Exclusion from participation in federal health care programs, such as Medicare and Medicaid.

The FCA includes qui tam or whistleblower provisions, which allow any person with actual knowledge of allegedly false claims to file a lawsuit on behalf of the federal government. These persons are referred to in the FCA as "relators." The relator must file his/her lawsuit on behalf of the government in a federal district court. The lawsuit must be filed "under seal," which means that it is kept confidential while the government is reviewing and investigating the allegations in the lawsuit and deciding how to proceed.

If the federal government determines that the lawsuit has merit and decides to intervene, the U.S. Department of Justice will handle prosecution of the case. If the government decides not to intervene, the relator can continue with the lawsuit on his/her own. The government may intervene later upon a showing of good cause.

Depending on whether the federal government intervenes or the relator pursues the case on his/her own and if the lawsuit is successful, the relator may receive a percentage of the award or settlement, depending on the relator's contribution to the case. The relator will also be entitled to reimbursement for reasonable expenses, attorney's fees and costs.

In a case pursued by the relator without the government, if the court finds the defendant not guilty and the relator's claim frivolous, the court may require the relator to reimburse the defendant's reasonable costs and attorney's fees.

If the court finds that the relator planned and initiated the violation upon which the lawsuit is based, the court may reduce the relator's share. If the relator is convicted of criminal conduct, the relator will be dismissed from the lawsuit and will not receive any reward.

The FCA protects employees who are involved in a qui tam lawsuit, such as filing a lawsuit, investigating a false claim, providing testimony or assisting with the lawsuit. An employee who has been discharged, demoted, suspended, threatened, harassed or in any way discriminated against by his/her employer because of the employee's involvement in a false claims disclosure will be entitled to all relief necessary to make the employee whole, including:

Reinstatement with the same seniority that the employee would have had but for the discrimination;

- 2 times the amount of back pay plus interest; and
- Compensation for any special damages sustained because of the discrimination, including litigation costs and reasonable attorney's fees.

5.2. Federal Anti-Kickback Statute 42 U.S.C. § 1320a-7b

The federal Anti-Kickback Statute prohibits any person from knowingly and willfully soliciting, receiving, offering or paying anything of value, directly or indirectly, overtly or covertly, in cash or

in kind, to a person or entity in return for furnishing, referring, ordering or recommending any item or service for which payment may be made in whole or in part by a federal health care program, such as Medicare or Medicaid. This is a criminal statute and requires proof of intent for a violation.

Violation of the Anti-Kickback Statute is a felony and will subject the violator to the following penalties for each violation:

- A fine of up to $25,000;
- Imprisonment for up to 5 years;
- Administrative civil monetary penalties of up to $50,000;
- Exposure to False Claims Act liability for claims submitted; and
- Exclusion from participation in federal and state health care programs, such as Medicare and Medicaid.

Employees and business partners should take special care regarding the giving or accepting of any gifts and/or potential conflict of interest that may arise with regard to the services provided at Healthcare Locations. See Group's Code of Business Conduct Policy for additional information on our Gift Policy and Conflict of Interest and mandatory disclosure required by Group Policy. If you have any questions as to whether a gift or relationship may be appropriate, seek guidance from the Compliance or Legal Department.

5.3. Civil Monetary Penalties Law 42 U.S.C. § 1320a-7a

The federal Civil Monetary Penalties Law ("CMPL") may impose additional penalties on any one who knowingly presents a claim to a federal or state officer, employee or agency if:

- The claim is for a service that the person knows or should know was not provided as claimed;
- The claim is for a service and the person knows or should know that the claim is false or fraudulent;
- The claim is for a service provided by a person who was excluded from participating in any federal health care program, such as Medicare or Medicaid, at the time the service was provided;
- The claim is for a pattern of services that the person knows or should know are not medically necessary;
- The person offers or gives something of value to a Medicare or Medicaid patient that the person knows or should know is likely to induce the patient to order or receive services for which Medicare or Medicaid pays;
- The person knows of any overpayment from the Medicare or Medicaid program and does not return the overpayment within the time period required by law; or
- The service or arrangement for services violates the federal Anti-Kickback Statute.

Penalties under the CMPL range from fines of $10,000 per service to $50,000 per violation and include exclusion from participating in any federal or state health care program.

5.4. Administrative Remedies for False Claims 31 U.S.C. §§ 3801-3812

Under this federal law, a federal agency may impose penalties on a person who makes, presents or submits a claim or written statement:

- That the person knows or has reason to know is false, fictitious or fraudulent;
- That includes or is supported by any written statement asserting a material fact that is false, fictitious or fraudulent or omitting a material fact; or
- That is for the provision of property or services that have not been provided.

Proof of specific intent to defraud is not necessary for a violation of this law.

The penalties for violation of this federal law are a civil penalty of up to $5,000 for each claim or statement and an assessment of twice the amount of the false, fraudulent or fictitious claim.

5.5. Health Care Fraud Statute 18 U.S.C. § 1347

This federal criminal statute imposes criminal penalties on an individual who knowingly and willfully executes or attempts to execute a scheme to defraud any health care benefit program (not just Medicare or Medicaid) or a scheme to obtain, by means of false or fraudulent pretenses, representations or promises, any money or property owned or controlled by a health care benefit program in connection with the delivery of or payment for health care services.

Violation of this law may result in criminal fines and/or the following prison terms:

- Up to 10 years for a violation;
- Up to 20 years if the violation results in serious bodily injury; or
- Any number of years to life if the violation resulted in death.

5.6. The Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191)

These federal regulations are called the HIPAA Privacy Regulations and require that we take extra precautions to safeguard the privacy of protected health information (PHI) of individuals from unauthorized access or disclosure. The US Department of Health and Human Services, Office of Civil Rights has the ability to impose civil monetary penalties for violation(s) of the HIPAA Privacy Regulations.

5.7. The Health Information Technology for Economic and Clinical Health Act (HITECH)

These federal regulations modified the privacy and security provisions of HIPAA discussed in Section 5.6. These regulations address the use of electronic health records, how to secure protected health information appropriately and when and to whom notifications should made in regard to data breaches of unsecured PHI. Violations of these regulations include civil monetary penalties, as well as criminal penalties for some HIPAA violations committed through willful neglect.

5.8. State Fraud & Abuse Laws

A compendium of state laws pertaining to fraud, waste and abuse can be found at Appendix A.

6. Detection and Prevention of Fraud, Waste and Abuse

6.1. Transdev will work to create an environment where it is difficult to commit fraud, waste or abuse. Our commitment to ensuring our collective compliance with the requirements of this Policy

include the following efforts:

6.1.1 Employees must conduct themselves in accordance with this Policy.

6.1.2 Employees must report any suspicions or knowledge of fraud, waste or abuse in accordance with this Policy.

6.1.3 The implementation of policies and procedures (like this Policy and the Compliance Program) to address suspected and detected fraud, waste and abuse, including its reporting (internal and external), tracking, and disciplinary standards.

6.1.4 The performance of risk assessments and data analysis to identify trends and potentially fraudulent activity, such as those contained within the Group Anti-Fraud Policy.

6.1.5 The conduct of thorough investigations of suspected fraud, waste or abuse, including collaborating with law enforcement on investigations at the local, state, and federal level.

6.1.6 The imposition of disciplinary and/or corrective action when appropriate.

6.2. We also will regularly monitor activity in areas typically susceptible to fraud, waste and abuse to assist in identifying fraud, waste and abuse. These steps include:

6.2.1 Active supervision of employees

6.2.2 Analysis of performance

6.2.3 Audit of performance (with regard to the risk from fraud, waste and abuse)

7. How to Report Healthcare Fraud, Waste and Abuse

7.1. If employees suspect fraud, waste or abuse in our business with the healthcare system, they can report it to us and we will investigate.

7.2. Any employee who suspects or becomes aware of fraud, waste and abuse with the healthcare system must report the matter immediately. Employees should report their suspicion or knowledge of wrongdoing or illegal acts to the appropriate Transdev General Manager provided that General Manager is not believed to be involved in the activity being reported.

Alternatively, reports may be made anonymously using the Transdev Ethics and Compliance hotline at 866-850-3033. You may also contact Internal Audit, Security and/or Legal.

You may also report suspected fraud, waste or abuse, directly to the Compliance Officer:

Julie Hein
Director of Healthcare Compliance
Transdev U.S.
720 E. Butterfield Rd, Suite 300
Lombard, IL 60148
email: Julie.Hein@transdev.com

Management within Transdev will ensure the matter is reported to the Compliance Officer, Group Security, Internal Audit and Legal.

All information received or discovered will be treated as confidential, and the results of investigations will be discussed only with persons having a legitimate reason to receive the information (e.g., state and federal authorities, corporate law department, market directors or company senior management).

Self-reporting is also encouraged. Anyone who reports his/her own violation will receive due consideration with regard to disciplinary action that may be taken.

Anyone who makes a report of a violation maliciously, frivolously or in bad faith will be subject to disciplinary action, including termination.

7.3. Transdev strictly forbids any retaliation or discrimination against anyone who makes a good faith report of a violation or cooperates in an investigation. Additionally, Transdev strictly forbids any intimidation meant to deter or prohibit good faith participation. If an employee or contractor believes that an adverse action in the form of retaliation or discrimination has been taken against him/her as a result of making a report of a violation, or experiences intimidation meant to deter or prohibit making a good faith report, the employee or contractor should report the retaliation or discrimination to his/her Transdev General Manager, provided that General Manager is not involved in the suspected retaliation or discrimination. In the alternative, the employee or contractor may report suspected the retaliation or discrimination by calling the Transdev Ethics & Compliance hotline at 1-866-850-3033 or by emailing us.compliance@transdev.com. You can also contact the Compliance Officer directly. Reports may also be made to Internal Audit, Group Security and/or Legal.

8. Investigating Fraud, Waste and Abuse

8.1. We will conduct investigations into suspected fraud, waste and abuse consistent with the procedures outlined in the Group Anti-Fraud Policy and Compliance Program.

8.2. If fraud is suspected or reported the matter will be referred by the business concerned to the Compliance Officer, Group Security, Legal and/or Group Internal Audit. An initial assessment will be made and fact finding undertaken.

8.3. Our assessment and fact finding process will vary, depending on the situation and the specific allegations. Steps may include the following:

8.3.1 Contact with relevant parties to gather information. This may include contacting relevant employees or other third parties to get a better understanding of the situation.

8.3.2 Requests for relevant records. We do this to validate that the records support the services provided and billed and that the correct billing procedures were used.

8.3.3 Notification of suspected fraud, waste and abuse to law enforcement and other relevant parties, such as the state Medicaid agency, and any other applicable state and/or federal agencies.

8.3.4 Depending upon the nature of the allegations, management from the business involved, Transit's Compliance Officer, Group Security, Group Internal Audit, Group Legal and Group Human Resources may be supported by other specialist resources, such as forensic investigators and other members of the Group Legal Department.

9. Breach of Policy

9.1. Fraud, waste and abuse impacts individuals, our businesses and the healthcare system. In many circumstances, committing acts of fraud, waste and abuse is a criminal offense and all allegations or suspicions of such activity will be robustly investigated.

9.2. If suspicions of fraud, waste and abuse are substantiated, the following action may be taken:

9.2.1 Disciplinary procedures (normally dismissal / termination)

9.2.2 Referral to the police (normally pursuit of criminal prosecution)

9.2.3 Civil litigation to recover any losses we have incurred

9.2.4 Notification of suspected fraud, waste and abuse to other relevant parties, such as the state Medicaid agency, and any other applicable state and/or federal agencies or law enforcement officials

10. Related Policies

10.1. The following code and policies are related to this Policy:

10.1.1 Group Corporate Social Responsibility

10.1.2 Group Code of Business Conduct

10.1.3 Group Anti-Bribery Policy

10.1.4 Group Whistleblowing Policy

10.1.5 Group Anti-Fraud Policy

10.1.6 Group Gifts and Hospitality Policy

10.1.7 Transdev's Compliance Program – Healthcare Services

11. Document History & Change Control

11.1. This document will be reviewed by the Business Owner within twelve months after the issue date and at least once every twelve months thereafter. It will be reviewed at other times as dictated by operational needs and changes to the underlying legal and regulatory position.

11.2. Requests for changes to this document must be sent to the Business Owner. All requests must provide details of the required changes and the reasons for the changes being requested. All adopted changes will be noted in the table below by the Business Owner.

11.3. Material changes will be subject to the approval of Transdev prior to implementation.

11.4. The Business Owner will update the table in Annex B to show the dates of any reviews and/or changes to this document.

Annex A: Compendium of State Laws Pertaining to Fraud, Waste and Abuse

State	Description
AZ	*Anti-Kickback Law (A.R.S. § 13-3713)* Under Arizona's anti-kickback law, it is unlawful for a person to knowingly offer, deliver, receive, or accept any rebate, refund, commission, preference or other consideration in exchange for a patient, client or customer referral to any individual, pharmacy, laboratory, clinic or health care institution providing medical or health-related services or items under the Arizona Health Care Cost Containment System (the Medicaid program). Violations of the statute are: (i) class 3 felony for payment of $1000 or more; (ii) a class 4 felony for payment of more than $100 but less than $1000; or (iii) a class 6 felony for payment of $100 or less.
AZ	*Improper Marketing and Inducements (AZ Admin. Code R9-22-504)* A contractor or a contractor's marketing representative shall not offer or give any form of compensation or reward, or engage in behavior or activity that can be reasonably construed to be coercive, to induce or procure an individual's enrollment with the contractor and the Medicaid program. Any marketing solicitation offering a benefit, good or service in excess of the covered services is deemed an inducement.
AZ	*False Claims Statute (A.R.S. § 36-2918)* The state false claims statute provides that a person may not present or cause to be presented a claim for medical or other service under the Arizona Health Care Cost Containment System to the State or to a contractor that the person has reason to know was not provided as claimed or is false or fraudulent or that the person knows or has reason to know that the person was terminated or suspended from the program or was not a member of the program when service was made, the service was substantially more than was needed or of a quality that does not meet professionally recognized standards of care. A person who violates this section is subject to, in addition to other penalties, a civil penalty not to exceed $2000 for each item or service claimed and is subject to an assessment not to exceed twice the amount claimed for each item or service.
AZ	*Duty to Report Fraud (A.R.S. § 36-2918.01)* All contractors, subcontracted providers of care and noncontracting providers shall notify the director of the Arizona Health Care Cost Containment System administration or director's designee immediately in a written report of any cases of suspected fraud or abuse involving the Arizona health care cost containment system. Failure to do so is considered an act of unprofessional conduct, subject to disciplinary action by the appropriate professional regulatory board or department. Information or records furnished in good faith pursuant to this section grants the person immunity from civil liability for the reason of providing the information.

State	Description
AZ	*Insurance Fraud (A.R.S. § 20-463)* In connection with a claim for payment or benefit from an insurance policy, it is unlawful and fraudulent practice for a person to knowingly present, prepare with knowledge or belief that it will be presented, or cause to be presented to an insurer, re-insurer, insurer of re-insurer insurance producer or agent of a re-insurer, untrue statements of material fact or statements omitting a material fact. This includes preparation of computer generated documents. It is also unlawful and a fraudulent practice for a person to knowingly assist, abet or conspire with another person to present such false statements or omissions.
AZ	*Medicaid Fraud (A.R.S. § 36-2905.04)* A person shall not provide or cause to be provided false or fraudulent information to the state as part of an application for coverage eligibility in the Arizona Health Care Cost Containment System. In addition to other penalties, if the person would have been ineligible for the system had true information been provided, the person providing the information is subject to a civil penalty not to exceed the amount incurred by the system on behalf of the person. In addition to requirements in state law, the Medicaid fraud and abuse controls that are enacted under federal law apply to all persons eligible for the system and all contractors, noncontracting providers and subcontracted providers that provide services to persons who are eligible for the system. A person who knowingly aids or abets a person under this section is guilty of a class 5 felony.
CA	*Anti-Kickback Law (Cal. Business & Professions Code § 650)* Under Section 650(a), California's principal anti-kickback statute, the offer, delivery, receipt, or acceptance by specified licensees of any rebate, refund, commission, preference, patronage dividend, discount, or other consideration, whether in the form of money or otherwise, as compensation or inducement for referring patients, clients, or customers to any person is unlawful. Penalties are stated by Section 650(g), which provides that a violation of Section 650 is a public offense and is punishable upon a first conviction by imprisonment in the county jail for not more than one year, or by imprisonment in the state prison, or by a fine not exceeding $50,000, or by both such imprisonment and fine. A second or subsequent conviction is punishable by imprisonment in the state prison or by imprisonment in the state prison and a fine of $50,000.
CA	*Additional Anti-Kickback Law (Cal. Health & Safety Code Section § 445)* This secondary California Anti-Kickback Statute prohibits referrals for profit to a physician, hospital, health-related facility, or dispensary for any form of medical care or treatment of any ailment or physical condition. The imposition of a fee or charge for any such referral or recommendation creates a presumption that the referral or recommendation is for profit. A physician, hospital, health-related facility, or dispensary shall not enter into a contract or other form of agreement to accept for medical care or treatment any person referred or recommended for such care or treatment by a medical referral service business located in or doing business in another state if the medical referral service business would be prohibited if located in California. Does not apply to referrals or recommendations that are made under the crippled children services program or prepaid health plans. A violation is a misdemeanor

State	Description
	punishable by imprisonment in the county jail for not longer than one year, or a fine of not more than $5,000, or by both. Violation may be enjoined in a civil action brought in the name of the people of the state of California by the Attorney General, except that the plaintiff shall not be required to allege facts necessary to show or tending to show lack of adequate remedy at law or to show or tending to show irreparable damage or loss.
CA	*Insurance Code Anti-Kickback Law (Cal. Insurance Code §§ 750, 754)* Under Insurance Code § 750(a), any person acting individually or through his or her employees or agents, who engages in the practice of processing, presenting, or negotiating claims, including claims under policies of insurance, and who offers, delivers, receives, or accepts any rebate, refund, commission, or other consideration, whether in the form of money or otherwise, as compensation or inducement to or from any person for the referral or procurement of clients, cases, patients, or customers, is guilty of a crime. Section 750(b) provides that such crime is punishable upon a first conviction by imprisonment in the county jail for not more than one year, or by imprisonment in the state prison, or by a fine up to $50,000, or by both. A second or subsequent conviction is punishable by imprisonment in the state prison or by imprisonment in the state prison and a fine of $50,000.
CA	*Workers Compensation Anti-Kickback Law (Cal. Labor Code § 3215)* California's main workers' compensation specific Anti-Kickback Statute provides that except as otherwise permitted by law, any person acting individually or through his or her employees or agents, who offers, delivers, receives, or accepts any rebate, refund, commission, preference, patronage, dividend, discount or other consideration, whether in the form of money or otherwise, as compensation or inducement for referring clients or patients to perform or obtain services or benefits payable under California's workers' compensation program is guilty of a crime.
CA	*Medicaid Anti-Kickback Law (Cal. Welfare & Institutions Code § 14107.2)* California's Medicaid anti-kickback law is similar to the federal Anti-Kickback Statute and prohibits any person from soliciting or receiving, offering or paying, any remuneration in any form directly or indirectly, overtly or covertly in cash or in kind, in return for the referral or promised referral of any individual to a person for furnishing any services or merchandise that is paid by California's Medi-Cal program. These provisions also prohibit remuneration in return for purchasing, leasing, ordering, or arranging for or recommending the purchasing, leasing, or ordering of any goods, facility, service, or merchandise for which payment may be made by Medi-Cal. The prohibition does not apply to payment to a bona fide employee, a discount or other reduction in price obtained by a provider of services or other entity if the reduction in price is properly disclosed and reflected in the costs claimed or charges made to the Medi-Cal program by the provider or entity. Violations of this statute are punishable upon a first conviction by imprisonment in the county jail for not longer than one year or state prison, or by a fine not exceeding $10,000, or by both. A second or subsequent conviction shall be

State	Description
	punishable by imprisonment in the state prison. The enforcement remedies provided under this section are not exclusive and shall not preclude the use of any other criminal or civil remedy. Unlike the federal Anti-Kickback Statute, the Medi-Cal statute provides for no regulatory "safe harbors" for certain types of arrangements, and does not require violations to be knowing and willful. While no cases have addressed the issue, the statute may be vulnerable to challenges of being preempted by federal law in these two respects.
CA	*Anti-Supplementation Law (Cal. Welfare & Institutions Code § 14107.3)* The anti-supplementation statute prohibits any person from knowingly and willfully charging, soliciting, accepting, or receiving, in addition to any amount payable under the Medi-Cal program any gift, money, contribution, donation, or other consideration as a precondition to providing services or merchandise to a Medi-Cal beneficiary for any service or merchandise in the Medi-Cal program's scope of benefits in addition to a claim submitted to the Medi-Cal program except either to collect payments due under a contractual or legal entitlement, bill a long term care patient or representative for the amount of the patient's share of the cost or return payment to a beneficiary who has aid for service. Violation is punishable upon a first conviction by imprisonment in the county jail for not longer than one year or state prison, or by a fine not to exceed $10,000, or both. A second or subsequent conviction shall be punishable by imprisonment in the state prison.
CA	*Title 22 California Code of Regulations § 51478* This regulation prohibits providers from offering, giving, furnishing, delivering, soliciting, requesting, accepting, or receiving any rebate, refund, commission preference, patronage dividend, discount, or any other gratuitous consideration in connection with the rendering of health care services to any Medi-Cal beneficiary.
CA	*False Claims Statutes - Penal Code § 550* California's main criminal prohibition of false claims to private insurers makes it a crime to knowingly present or cause to be presented any false or fraudulent claim for the payment of a loss or injury, including payment of a loss or injury under a contract of insurance (or to aid, abet, solicit, or conspire with any person to do so). Penal Code § 550(c)(1) provides that every person who violates Section 550(a)(1) is guilty of a felony punishable by imprisonment for two, three, or five years, and by a fine not exceeding $50,000, or double the amount of the fraud, whichever is greater.

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CA	*Insurance Code § 1871.7* This statute piggybacks off of the above Penal Code § 550 to provide California's main civil provision prohibiting false claims to private insurers. Insurance Code § 1871.7(b) provides that every person who violates any provision of this section or Sections 549, 550, or 551 of the Penal Code shall be subject, in addition to any other penalties that may be prescribed by law, to a civil penalty of not less than $5,000 nor more than $10,000, plus an assessment of not more than three times the amount of each claim for compensation. The district attorney or Insurance Commissioner may bring a civil action under this section, and any interested persons, including an insurer, may bring a civil action for a violation of this section for the person and for the State of California, with a recovery of any penalties available to be paid to the whistleblower.
CA	*Government Code §§ 12650- 12652* These provisions constitute the California False Claims Act and are the state's most important antifraud provisions involving government programs. Government Code § 12651(a) prohibits a person from knowingly making false claims or causing false claims to be made for money, property, or services to the state or any of its political subdivisions, or to any contractor, grantee, or other recipient, whether under contract or not, if any portion of the money, property, or services requested or demanded issued from, or was provided by, the state or by any political subdivision. Additional prohibitions are included that parallel those of the federal False Claims Act. Liability to the state or a political subdivision for violation is for up to treble damages, the costs of a civil action for recovery for recovery of penalty or damages, and may include a civil penalty of not less than $5,000 and not more than $10,000 for each false claim. Penalties may be reduced if the person cooperates with the fraud investigation. Does not apply to any controversy involving an amount of less than $500 in value. Actions by qui tam plaintiffs (whistleblowers) are authorized and governed by Government Code § 12652.
CA	*Welfare & Institutions Code § 14043.36* This statute prohibits enrollment in the state Medicaid program (Medi-Cal) for any applicant that has been convicted of any felony or misdemeanor involving fraud or abuse in any government program, or related to neglect or abuse of a patient in connection with the delivery of a health care item or service, or in connection with the interference with or obstruction of any investigation into health care-related fraud or abuse or that has been found liable for fraud or abuse in any civil proceeding, or that has entered into a settlement in lieu of conviction for fraud or abuse in any government program, within the previous 10 years. The Medi-Cal program may also deny enrollment to any applicant that at the time of application is under investigation by the department or any state, local, or federal government law enforcement agency for fraud or abuse. The Medi-Cal program, may not deny enrollment to an otherwise-qualified applicant whose felony or misdemeanor charges did not result in a conviction solely on the basis of the prior charges. Providers are also subject to temporary

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	suspension, pursuant to a 15-day notification, from the Medi-Cal program, which shall include temporary deactivation of all provider numbers, including all business addresses, used by the provider to obtain reimbursement from the Medi-Cal program, if it is discovered that a provider is under investigation for fraud or abuse.
CA	*Welfare & Institutions Code § 14043.61* A Medi-Cal provider is subject to suspension if claims for payment are submitted for the services, goods, supplies, or merchandise provided, directly or indirectly, to a Medi-Cal beneficiary by an individual or entity that is suspended, excluded, or otherwise ineligible for reimbursement from the Medi-Cal program and the individual or entity is listed on either the Suspended and Ineligible Provider List, published by the department or any list published by the federal Office of Inspector General regarding the suspension or exclusion of individuals or entities from the federal Medicare and Medicaid programs.
CA	*Welfare & Institutions Code § 14107* This statute prohibits a person, including an applicant or provider in the Medi-Cal program or a billing agent from engaging in certain activities under threat of punishment by imprisonment, by a fine not exceeding three times the amount of the fraud or improper reimbursement or value of the scheme or artifice, or by both, and shall be subject to the asset forfeiture provisions for criminal profiteering, and any other criminal or civil remedy. Prohibited activities are filing false or fraudulent claims for payment in the Medi-Cal program, with intent to defraud; knowingly submitting false information for the purpose of obtaining greater compensation than that to which he or she is legally entitled under the Medi-Cal program; knowingly submitting false information for the purpose of obtaining authorization for furnishing services or merchandise in the Medi- Cal program or knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud Medi-Cal or any other health care program administered by the department or its agents or contractors or to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, the Medi- Cal program or any other health care program administered by the Department or its agents or contractors, in connection with the delivery of or payment for health care benefits, services, goods, supplies, or merchandise.
CA	*Welfare & Institutions Code § 14123* This statute permits the director of the Department of Health Services to suspend a service provider indefinitely, with or without conditions, for violation of any provisions of the Medi-Cal statute or regulations and requires the director to suspend a provider for conviction of any felony or any misdemeanor involving fraud, abuse of the Medi- Cal program or any patient, or otherwise substantially related to the qualifications, functions, or duties of a provider of service.

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CA	*Welfare & Institutions Code § 14123.2* This statute requires the director of the Department of Health Services to determine, in addition to any other penalties that may be prescribed by law, assessment of civil money penalties, of not more than three times the amount claimed for each item or service, and to collect penalties against any provider or person that presents or causes to be presented a claim for services that the director determines is for a medical or other item or service that the person knows or has reason to know (a) was not provided as claimed, or (b) payment for which may not be made under the program when the person or provider has been suspended from participation in the program; the Department determines that the services or items claimed are substantially in excess of the needs of individuals or are of a quality that fails to meet professionally recognized standards of health care; the Department determines that a person has demonstrated a pattern of abusive overbilling of the program; when the Department determines that a person has intentionally or negligently made a false statement or representation on any request for payment submitted to the Medi-Cal program; or (c) is submitted in violation of an agreement between the person and the state. The statute permits the imposition of civil money penalties for continuing intentional violations, in the amount of not more than three times the amount claimed for each item or service for each day the violation continues.
CA	*Welfare & Institutions Code § 14123.25* This statute authorizes the Department of Health Services to impose mandatory and permissive exclusions from the Medi-Cal program as authorized by federal regulations and impose civil money penalties against applicants and providers or against billing agents, as defined in statute, in lieu of, or in addition to, the imposition of any other sanctions available under state statute. It also permits the Department to terminate, or refuse to enter into, a provider agreement for participation in the Medi-Cal program pursuant to federal law. Where the action is based upon a conviction for any crime involving fraud or abuse in the Medi-Cal, Medicaid, or Medicare programs, or an exclusion by the federal government from the Medicaid or Medicare programs, the action shall be automatic and not subject to appeal or hearing.
CA	*Title 22 California Code of Regulations §§ 51485-51485.1* These regulations prohibit a provider from submitting false or misleading information of material fact when complying with Medi-Cal regulations, or in connection with any claim for reimbursement, or any request for authorization of services. Permits the director of the Department of Health Services to impose civil money penalties, up to three times the amount claimed by the provider for each item or service, if Department determines that the provider knows or had reason to know that items or services were not provided as claimed, are not reimbursable under the Medi-Cal program, or were claimed in violation of an agreement with the state.

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CT	*Anti-Kickback Law (Conn. Gen. Stat. § 53a-161c)* Except as expressly permitted under the federal Anti-kickback Statute safe harbor regulations, the Connecticut law states that a person is guilty of receiving kickbacks when he "knowingly solicits, accepts or agrees to accept any benefit, in cash or in kind, from another person upon an agreement or understanding that such benefit will influence such person's conduct in relation to referring an individual or arranging for the referral of an individual for the furnishing of any goods, facilities or services to such other person under contract to provide goods, facilities or services to a local, state or federal agency." Receiving kickbacks is a felony. Similarly, it is a felony for anyone to knowingly offer or pay any benefit, "in cash or kind, to any person with intent to influence such person: (1) To refer an individual, or arrange for the referral of an individual, for the furnishing of any goods, facilities or services for which a claim for benefits or reimbursement has been filed with a local, state or federal agency; or (2) to purchase, lease, order or arrange for or recommend the purchasing, leasing or ordering of any goods, facilities or services for which a claim of benefits or reimbursement has been filed with a local, state or federal agency."
CT	*Health Insurance Fraud (Conn. Gen. Stat. § 53-442)* Under this statute, a person is guilty of health insurance fraud when, he presents or causes to be presented to any insurer or insurer's agent any statement as part of or in support of any claim for payment, with knowledge that the statement contains "false, incomplete, deceptive or misleading information concerning any fact or thing material to such claim or application, or omits information concerning any fact or thing material to such claim or application." It is also a violation to assist, abet, solicit or conspire to prepare or present any such statements in support of such claims. The statute provides specifically that "misleading information" "includes but is not limited to falsely representing that goods or services were medically necessary in accordance with professionally accepted standards." Anyone who violates the Health Insurance Fraud Act is subject to the penalties for larceny, as well as being required to make restitution to the aggrieved insurer, including attorneys' fees and investigative costs. State law also requires persons with knowledge of or reason to suspect health insurance fraud to provide notice and supporting information in the person's possession to the Insurance Commissioner (Conn. Gen. Stat. § 53-445). The Commissioner is required to review and investigate all such report as well as to conduct an independent investigation of the suspected fraud and, when applicable, to refer the investigation to the appropriate state agency for criminal or civil enforcement or disciplinary action. Any person disclosing suspect health insurance fraud may disclose otherwise protected personal or privileged information concerning possible health insurance fraud, so long as the disclosure is limited to what is reasonably necessary to detect, investigate or prevent fraud, criminal activity, material misrepresentation or material nondisclosure. No person shall be subject to liability, including liability for libel or slander, in connection with providing information pursuant to these provisions, unless that person did so "with malice or willful intent to injure any person.

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CT	*Vendor Fraud (Conn. Gen. Stat. § 53a-290)* A person commits vendor fraud when, with intent to defraud, the person provides services to a beneficiary under the Medicaid program and presents a false claim for payment, accepts payment in excess of the amount due or authorized by law for such services, solicits to perform the services for a beneficiary knowing the beneficiary does not need such services, performs services without prior authorization by the Department or Social Services where such prior authorization is required, or accepts from anyone but the state any additional compensation in excess of the amount authorized by law. Vendor fraud can constitute a misdemeanor or felony, depending on the resulting payment amount, and any state franchise or license held by a person found guilty of vendor fraud shall be revoked. Any vendor convicted in any state or federal court of a crime involving fraud in the Medicare or Medicaid program shall be terminated from those programs.
FL	*Florida Anti-Kickback Law (Fl. Rev. Stat. 456.054)* It is unlawful for any healthcare provider or any provider of healthcare services to offer, pay, solicit, or receive a kickback, directly or indirectly, overtly or covertly, in cash or in kind, for referring or soliciting patients. A kickback means remuneration or payment, by or on behalf of a provider of healthcare services or items, to any person as an incentive or inducement to refer patients for past or future services or items, when the payment is not tax deductible as an ordinary and necessary expense. Violations are considered patient brokering and punishable under Florida's Patient Brokering Act.
FL	*Medicaid Provider Fraud (Fl. Rev. Stat. 409.920(2)(e)* It is unlawful to knowingly solicit, offer, pay, or receive any remuneration, including any kickback, bribe, or rebate, directly or indirectly, overtly or covertly, in cash or in kind, in return for referring an individual to a person for a furnishing or arranging for the furnishing of any item or service for which payment may be made, in whole or in part, under the Medicaid program, or in return for obtaining, purchasing, leasing, ordering, or arranging for or recommending, obtaining, purchasing, leasing, ordering or any goods, facility, item or service, for which payment may be made, in whole or in part, under the Medicaid program. Violating this section is a felony of the third degree, punishable by up to a $5,000 fine, five years' imprisonment, or both.
FL	*Florida False Claims Statute. (Fl. Rev. Stat. 68.081-68.09)* The Florida False Claims Act is very similar to the Federal False Claims Act. The FFCA imposes liability on any person who: knowingly presents or causes to be presented to an agent or employee of a Florida executive branch agency a false or fraudulent claim for payment or approval; knowingly makes, uses, causes to be made or used a false statement in support of false or fraudulent claim; or conspires to submit a false or fraudulent claim to or deceive an agency to get a false or fraudulent claim paid or approved. The FFCA lists additional violations, which are similar in substance to the Federal False Claims Act. The definitions of "knowing" and "knowingly" are similar to federal False Claims Act: actual knowledge; deliberate ignorance or reckless disregard of truth or falsity. Specific intent to defraud is not required for liability. The FFCA provides for treble damages, which the court may reduce to

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	double damages under specific extenuating circumstances; and imposes a civil penalty of not less than $5,500 but not more than $11,000. Florida law also protects whistleblowers from retaliation. Under pertinent law, any employee discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment by his or her employer because of lawful acts done by the employee on behalf of the employee or others in furtherance of a FFCA action, including investigation for initiation of, testimony for, or assistance in an action filed or to be filed, has a cause of action under the Florida Whistle-blower's Act.
FL	*Powers of the Agency for Health Care Administration (Fl. Rev. Stat. 409.913)* This law empowers the Agency for Health Care Administration (AHCA) to have oversight program to minimize fraud and abuse, and neglect of Medicaid recipients. The statute provides general authority to recover overpayments and impose sanctions and requires AHCA directly or by contract to conduct reviews, investigations, analyses, and audits to determine possible overpayment, fraud, abuse, or recipient neglect. The law also imposes affirmative duty on providers to be responsible for presenting claims that are true and accurate, and are for services that: have actually been furnished; Medicaid covered and medically necessary; are of appropriate quality; were provided in compliance with all applicable state and federal laws and Medicaid program requirements; are properly documented to demonstrate medical necessity. AHCA may deny payment or require repayment for claims not meeting these requirements. AHCA may also deny payment or require repayment for inappropriate, medically unnecessary or excessive goods and services from: person furnishing them; person supervising them; or person causing them to be furnished. Billing agents or others preparing Medicaid claims may not be paid based on amounts billed to or received from Medicaid. AHCA must suspend or terminate providers from Florida Medicaid program if a provider is suspended or terminated from Medicaid or Medicare by federal government or any state for at least as long as the other suspension or termination. Other sanctions include suspension up to one year; termination for over one year up to twenty years; and fines up to $5,000 fine per violation.
FL	*Medicaid Fraud (Fla. Rev. Stat. Ann. 409.920)* This statute establishes a number of activities that constitute Medicaid fraud. In particular, it is unlawful to knowingly: (i) Make, cause to be made, or aid and abet in the making of any false statement or false representation of a material fact, by commission or omission, in any claim submitted to the agency or its fiscal agent for payment; (ii) Make, cause to be made, or aid and abet in the making of a claim for items or services that are not authorized to be reimbursed by the Medicaid program; (iii) Charge, solicit, accept, or receive anything of value, other than an authorized copayment from a Medicaid recipient, from any source in addition to the amount legally payable for an item or service provided to a Medicaid recipient under the Medicaid program or knowingly fail to credit the agency or its fiscal agent for any payment received from a third-party source; (iv) Make or in any way cause to be made any false statement or false representation of a material fact, by

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	commission or omission, in any document containing items of income and expense that is or may be used by the agency to determine a general or specific rate of payment for an item or service provided by a provider; (v) Solicit, offer, pay, or receive any remuneration, including any kickback, bribe, or rebate, directly or indirectly, overtly or covertly, in cash or in kind, 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 Medicaid program, or in return for obtaining, purchasing, leasing, ordering, or arranging for or recommending, obtaining, purchasing, leasing, or ordering any goods, facility, item, or service, for which payment may be made, in whole or in part, under the Medicaid program; (vi) Submit false or misleading information or statements to the Medicaid program for the purpose of being accepted as a Medicaid provider; (vii) Use or endeavor to use a Medicaid provider's identification number or a Medicaid recipient's identification number to make, cause to be made, or aid and abet in the making of a claim for items or services that are not authorized to be reimbursed by the Medicaid program. Violation of the law is a felony of the third degree, punishable by up to a $5,000 fine, five years' imprisonment, or both.
FL	*Insurance Fraud (Fla. Rev. Stat. Ann. 817.234)* Under this law, it is unlawful to, with the intent to injure, defraud, or deceive any insurer, present, cause to be presented, prepare or make any statement in support of a claim or benefit under an insurance policy or HMO subscriber or provider contract, knowing that such statement is false, incomplete or misleading regarding any fact or thing material to the claim. Violations of this statute constitute a felony, and penalties increase in severity based on value of property involved. If the value of any property involved in a violation of this section: (i) Is less than $20,000, the offender commits a third-degree felony, punishable by up to a $5,000 fine, five years' imprisonment, or both; (ii) Is $20,000 or more, but less than $100,000, the offender commits a second-degree felony, punishable by up to a $10,000 fine, fifteen years' imprisonment, or both; (iii) Is $100,000 or more, the offender commits a first- degree felony, punishable by up to a $10,000 fine, thirty years' imprisonment, or both.
IL	*Whistleblower Reward and Protection Act (740 ILCS 175)* The Illinois Whistleblower Reward and Protection Act is modeled after the federal False Claims Act. The Act prohibit a person from knowingly (i.e., the person either has actual knowledge of the information, acts in deliberate ignorance of the truth or falsity of the information, or acts in reckless disregard of the truth or falsity of the information) making claims for money or property to an officer, employee, contractor, grantee or other recipient if the State provides any portion of the money or property which is requested or demanded, or if the State will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded. No proof of specific intent to defraud is required. Liability to the state is for up to treble damages, the costs of a civil action for recovery for recovery of penalty or damages, and may include a civil penalty of up to $11,000 for each false claim when violation specific acts. Penalties may be reduced if the person cooperates with the fraud investigation. The Act allows for private attorney generals/qui tam relators.

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IL	*Whistleblower Act (740 ILCS 174)* This statute prohibits retaliation against employees for disclosing information to a government agency, where the employee has reasonable cause to believe that the information discloses a violation of a State or federal law.
IL	*Public Assistance Fraud (305 ILCS 5/8A-3)* The Illinois Public Assistance Fraud statute is modeled after the Federal anti-kickback statute. Under this statute, any person, firm, corporation, association, agency, institution or other legal entity shall be guilty of violating the statute if it, among other things, "willfully, by means of a false statement or representation, or by concealment of any material fact or by other fraudulent scheme or device on behalf of himself or others, obtains or attempts to obtain benefits or payments under this Code to which he or it is not entitled, or in a greater amount than that to which he or it is entitled," or "if he solicits or receives or offers or pays any remuneration, including any kickback, bribe, or rebate, directly or indirectly, overtly or covertly, in cash or in kind in return for referring or arranging for an item or service reimbursed, in whole or in part," under the Illinois Medicaid program. Penalties for violations of this statute include criminal sanctions and the imposition of civil remedies.
IN	*Anti-Kickback Statute (Indiana Code § 12-15-24-2)* It is unlawful for a person who furnishes items or services to an individual for which payment is or may be made from the Medicaid program to solicit, offer, or receive a: (1) kickback or bribe in connection with the furnishing of the items or services or the making or receipt of payment; or (2) rebate of a fee or charge for referring the individual to another person for the furnishing of items or services. Violation of this section is a Class A misdemeanor.
IN	*False Claims Statute (Indiana Code § 5-11-5.5-1 and § 5-11-5.5-2)* This law prohibits a person from knowingly (either has actual knowledge of the information, acts in deliberate ignorance of the truth or falsity of the information, or acts in reckless disregard of the truth or falsity of the information) or intentionally: (1) presenting a false claim to the state for payment or approval; (2) making or using a false record or statement to obtain payment or approval of a false claim from the state; (3) with intent to defraud the state, delivering less money or property to the state than the amount recorded on the certificate or receipt the person receives from the state; (4) with intent to defraud the state, authorizing issuance of a receipt without knowing that the information on the receipt is true; (5) receiving public property as a pledge of an obligation on a debt from an employee who is not lawfully authorized to sell or pledge the property; (6) making or using a false record or statement to avoid an obligation to pay or transmit property to the state; or (7) conspiring with, causing, or inducing another to perform one of the aforementioned acts. A person who violates this section is liable for a civil penalty of at least $5,000 and for up to three times the amount of damages sustained by the state, in addition to the costs of a civil action brought to recover the penalty or damages. If, however, it is determined that the person who violated this section furnished state officials with all information known to the

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	person about the violation not later than 30 days after the date on which the person obtained the information, fully cooperated with the investigation of the violation, and did not have knowledge of the existence of an investigation, criminal prosecution, civil action, or an administrative action concerning the violation at the time the person provided the information, the person is liable for a penalty of not less than two times the amount of damages that the state sustained and for the costs of a civil action brought to recover the penalty or damages.
IN	*Medicaid Fraud (Indiana Code § 35-43-5-7.1)* This statute prohibits a person from knowingly or intentionally filing a claim, including an electronic claim, for services in violation of the Indiana statutory Medicaid provisions set forth in Indiana Code Section 12-15, or from obtaining payment from the Medicaid program by means of false or misleading oral or written statements or other fraudulent means. This section also prohibits a provider from acquiring a provider number under the Medicaid program, except as authorized by law, concealing information for the purpose of applying for or receiving unauthorized Medicaid payments, or altering with the intent to defraud or falsifying a provider's documents or records that are required to be kept under the Medicaid program. A violation of this section constitutes Medicaid fraud, a Class D felony. If the fair market value of the offense is at least $100,000, the offense is considered a Class C felony.
IN	*Insurance Fraud (Indiana Code § 35-43-5-4.5 and § 34-24-3-1)* It is insurance fraud for a person knowingly and with intent to defraud to make, utter, present, or cause to be presented to an insurer or an insurance claimant a claim statement that contains false, incomplete, or misleading information concerning the claim, or to present, cause to be presented, or prepare with knowledge or belief that it will be presented to or by an insurer, an oral, written, or electronic statement that the person knows to contain materially false information concerning a fact material to a claim for payment or benefit under an insurance policy, or payments made in accordance with the terms of an insurance policy. Persons committing insurance fraud with prior, unrelated insurance fraud convictions or where the value of the property or benefits at issue are at least $2,500 are liable for a Class C felony. Otherwise violations are a Class D felony.
IN	*Medicaid Overpayment Sanctions (Indiana Code §§ 12-15-23-2 – 5)* This statute provides that the Office of the Secretary of Family and Social Services or administrator of the office may deduct overpayments from subsequent payments to the provider, including interest due from the provider for the amount of the overpayment. Allows a provider and administrator of the Office of Medicaid Policy and Planning 60 days after discovery of an overpayment to enter an agreement for return of the overpayment and interest. If the parties fail to enter into such an agreement, the administrator is required to certify the facts of the case to the Medicaid Fraud Control Unit.
IN	*Medicaid Fraud Control Unit Investigations (Indiana Code §§ 12-15-23-6 – 8)* Investigations by the Medicaid Fraud Control Unit ending in a determination that a crime may have been committed by a provider shall be certified and submitted to the prosecuting

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	attorney in the judicial circuit in which the crime may have been committed. The prosecuting attorney may refer the matter to the attorney general who may bring a civil action or refer a provider for sanctions to the administrator of the Office of Medicaid Policy and Planning under Indiana Code Section 12-15-22. Judgment in favor of the attorney general in a civil action may result in a penalty against the provider of not more than three times the amount paid to the provider in excess of the amount that was legally due, a civil penalty of not more than $500 for each instance of overpayment found by the court, and/or an order that the provider reimburse the attorney general for the reasonable costs of investigation and enforcement action. The court may only assess a civil penalty and order reimbursement of court and investigation costs if the provider knew or had reason to know that an item or a service was not provided as claimed.
KS	*Anti-Kickback Statute (K.S.A. 21-5928)* It is unlawful in Kansas to knowingly and intentionally solicit or receive (on the one hand) or offer or pay (on the other hand) any remuneration, including but not limited to any kickback, bribe, or rebate, directly or indirectly, overtly or covertly, in cash or in kind:in return for (1) referring or refraining from referring an individual to a person for the furnishing or arranging for the furnishing of any goods, service, item, facility, or accommodation; or (2) purchasing, leasing, ordering, or arranging for or recommending such actions with respect to any goods, service, items facility, or accommodation, for which payment may be made in whole or in part by the Medicaid program. There is an exception for a refund, discount, copayment, deductible, incentive, or other reduction obtained by a provider in the ordinary course of business and appropriately reflected in claims or reports submitted to the fiscal intermediary; there is another exception for deductibles, copayments, or other cost- or risk-sharing arrangements that are part of any program operated by or pursuant to contracts with the Medicaid program. A violation is a severity level 7, nonperson felony and is also subject to statutorily required restitution plus interest and payment of the costs of enforcement, including litigation and attorney fees.
KS	*Medicaid Fraud (K.S.A. 21-5927(a))* Making a false claim to the Medicaid program is, with intent to defraud, engaging in a pattern of making or presenting, or causing to be made or presented, in connection with any payment under the Medicaid program, any false or fraudulent claim, statement, report, or representation: (1) for payment for any goods, service, item, facility, accommodation; (2) for use in determining payments; (3) that may be used in computing or determining a rate of payment for any goods, service, item, facility, or accommodation; (4) in connection with any report or filing that is or may be used in computing or determining a rate of payment for any goods, service, item, facility, or accommodation; (5) for use by another in obtaining any goods, service, item, facility, or accommodation; (6) 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; (7) that is required to be kept or that 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; (8) in connection with any audit or investigation involving any claim for payment or rate of payment for any goods, service, item, facility, or accommodation; or (9) with the intent to influence any acts or decision of any official, employee, or agent of a state

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	or federal agency having regulatory or administrative authority over the Kansas Medicaid program. Making a false claim to the Medicaid program where the aggregate amount of payments illegally claimed is $25,000 or more is a severity level 7, nonperson felony; making a false claim to the Medicaid program where the aggregate amount of payments illegally claimed is at least $1,000 but less than $25,000 is a severity level 9, nonperson felony; making a false claim to the Medicaid program where the aggregate amount of payments illegally claimed is less than $1,000 is a misdemeanor. As defined by subsections (a)(8) and (a)(9) above, making a false claim to the Medicaid program is a severity level 9, nonperson felony.
KS	*Kansas False Claims Act (K.S.A. 75-7501 – 7511)* The Kansas False Claims Act was enacted in 2009 to provide another tool for pursuing those who knowingly receive state funds after having submitted a false or fraudulent claim. A person is in violation of the Act if that person: (1) knowingly presents or causes to be presented to any employee of the government or any other recipient of state funds, 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 to get a fraudulent claim approved; (3) defrauds the state by getting a false claim allowed or paid by using a false record to avoid or decrease an obligation to pay money to the state; (4) has possession of public property or money used or to be used by the state and knowingly delivers less property or money than the amount for which the person receives a certificate or receipt; (5) knowingly makes or delivers a receipt falsely representing property received that is to be used by the state; (6) knowingly buys or receives a pledge of an obligation or debt, public property from any person who may not sell or pledge the property; (7) benefits from a false claim to an employee or agent of the state, who subsequently discovers the falsity of the claim and fails to disclose the false claim and make satisfactory repayment to the state; or (8) conspires to commit any of the violations stated above. "Claim" is defined as any request or demand for money, property, or services made to a state employee if the state provides any portion of the money, property, or services requested. "Person" includes any natural person, corporation, firm, association, organization, partnership, business, or trust. A person who commits any of the acts set out above is liable to the state for three times the amount of damages incurred by the state because of the act and shall be liable for a civil penalty of not less than $1,000 and not more than $11,000 for each violation. A civil action may not be brought more than six years after the date of the violation or more than three years after the date on which the violation was discovered or should have reasonably been discovered. In no event may a civil action be brought more than 10 years after the date of the violation.

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KS	*Insurance Fraud (K.S.A. 40-2,118)* A "fraudulent insurance act" means 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 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 that 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. A fraudulent insurance act shall constitute a felony if the amount involved is equal to or more than $1,000; a fraudulent insurance act shall constitute a misdemeanor if the amount is less than $1,000. In addition to any other penalty, a person who commits a fraudulent insurance act 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 action.
KY	*Anti-Kickback Statute (KRS 205.8461)* Kentucky has adopted an anti-kickback proscription similar to the federal Anti-Kickback Statute, which incorporates elements of the federal prohibition on self-referral. Kentucky law provides: (1) except as otherwise provided in KRS 205.510 to 205.630, which authorizes recovery from third parties for services rendered, also known as Kentucky's "Medical Assistance Act," that no provider shall knowingly solicit, receive, or offer any remuneration (including any kickback, bribe, or rebate) for furnishing medical assistance benefits or in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any goods, facility, service, or item for which payment may be made pursuant to Title XIX of the Social Security Act; (2)(a) no provider shall knowingly make, offer, or receive a payment, a rebate of a fee, or a charge for referring a recipient to another provider for furnishing of benefits. Exceptions to this prohibition include any conduct or activity that does not violate or that is protected under the provisions of either the Stark Law, 42 U.S.C. § 1395nn, or the federal Anti-Kickback Statute, 42 U.S.C. § 1320A-7b(b), as amended, or federal regulations promulgated under those statutes. Such conduct or activity shall not be deemed to violate the provisions of the Kentucky Control of Fraud and Abuse laws, KRS 205.8451 to 205.8483, and shall be accorded the same protections allowed under federal law and regulation. Any person who violates subsection (1) or (2) of this statute shall be guilty of a Class A misdemeanor unless the combination or aggregation of offenses is valued at $300 or more, in which case it shall be a Class D felony. In addition to any other penalty authorized by law, any person who violates the provisions of subsection 2(a) shall not be entitled to bill or collect from the recipient or any third-party payer and shall repay any payments due the Commonwealth for services provided that were related to the referral.

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KS	*Kentucky Fraud & Abuse Laws (KRS 205.8451 to 205.8483)* Similar to the federal False Claims Act, the Kentucky fraud laws impose liability on persons or organizations that make or cause to be made false or fraudulent claims to the government for payment or who knowingly make, use, or cause to be made or used, a false record or statement to get a false or fraudulent claim paid by the government. Any provider found to have knowingly violated the Kentucky fraud laws shall be liable for: (1) restitution in the amount of the excess payments, plus interest; (2) a civil payment in an amount up to three times the amount of excess payments; (3) a civil payment of $500 for each false or fraudulent claim submitted for providing treatment, services, or goods; and (4) payment of legal fees and costs of investigation and enforcement of civil payments. In addition, those found to have violated the Kentucky laws will be removed as a participating provider in the Medical Assistance Program for two months to six months for a first offense, for six months to one year for a second offense, and for one year to five years for a third offense. Any person who knows or has reasonable cause to believe that a violation of the Kentucky Medicaid fraud law is being committed is required to report the violation to the Medicaid Fraud Control Unit or the Medicaid Fraud and Abuse hotline. Employers are not permitted, without just cause, to discharge or in any manner retaliate against any employee who in good faith makes such a report, or who participates in any proceeding with regard to any such report or investigation. An employee injured by any act in violation of the prohibition against employer retaliation may pursue a civil cause of action to enjoin further violations, and to recover the actual damages sustained, together with the costs of the lawsuit, including reasonable attorney's fees.
KS	*Medicaid Fraud (KRS 205.8463)* Under Kentucky's Medicaid Fraud statute: (1) No person shall knowingly or wantonly devise a scheme or plan a scheme or artifice, or enter into an agreement, combination, or conspiracy to obtain or aid another in obtaining payments from any medical assistance program under this chapter by means of any fictitious, false, or fraudulent application, claim, report, or document submitted to the Cabinet for Health and Family Services, or intentionally engage in conduct that advances the scheme or artifice. (2) No person shall intentionally, knowingly, or wantonly make, present, or cause to be made or presented to an employee or officer of the Cabinet for Health and Family Services any false, fictitious, or fraudulent statement, representation, or entry in any application, claim, report, or document used in determining rights to any benefit or payment. (3) No person shall, with intent to defraud, knowingly make, or induce, or seek to induce the making of a false statement or false representation of a material fact with respect to the conditions or operations of an institution or facility in order that the institution or facility may qualify, upon initial certification or upon recertification, as a hospital, skilled-nursing facility, intermediate-care facility, home health agency, or other provider of services to the Medical Assistance Program. (4) No person shall, in any matter within the jurisdiction of the Cabinet for Health and Family Services under this chapter, knowingly falsify, conceal, or cover up by any trick, scheme, or device a material fact, or make any false, fictitious, or fraudulent statement or

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	representation, or make or use any false writing or document knowing the same to contain any false, fictitious, or fraudulent statement or entry. (5) Any person who violates subsections (1) and (2) of this section shall be guilty of a Class A misdemeanor unless the sum total of benefits or payments claimed in any application, claim, report, or document, or in any combination or aggregation thereof, is valued at $300 or more in which case it shall be a Class D felony. Any person who violates the provisions of subsection (3) of this section shall be guilty of a Class C felony. Any person who violates the provisions of subsection (4) of this section shall be guilty of a Class D felony.
KS	*Provider Participation Requirements (907 KAR 1:671)* This regulation establishes provisions relating to Medicaid provider participation, recoupment of overpayments, identification and referral of unacceptable practices, withholding of payments during an investigation, the appeals process, and sanctions. It includes the requirement not to submit a "false claim," or commit an "unacceptable practice" that constitutes "fraud" or "provider abuse." Prohibited activities include: (1) Submitting a claim for medical care, services, or supplies that were not furnished (907 KAR 1:671.1(20)(a)); (2) Submitting a claim for medical care, services, or supplies that are in excess of accepted standards of practice for the medical care or other type of service, i.e., not medically necessary (907 KAR 1:671.1(20)(b))(also specifically included in definition of "provider abuse" in KRS 205.8451(8)); (3) Submitting a claim for medical care, services, or supplies that are in excess of established limits communicated, in writing, to providers by the state Medicaid agency (907 KAR 1:671.1(20)(b)); (4) Failing to bill a third-party payer when the provider knows there is third-party coverage for the recipient (907 KAR 1:671(20(b)); (5) Knowingly submitting, or causing the submission of false claims, or inducing, or seeking to induce, a person to submit false claims (907 KAR 1:671(40)(a)); (6) 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 (907 KAR 1:671(40)(b)); (7) Soliciting or accepting kickbacks, bribes, or rebates in exchange for referring goods, facilities, services, or items that are reimbursed by government programs (KRS 205:8461 & 907 KAR 1:671.1(40)(e)); (8) 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 (907 KAR 1:671(40)(f)); (9) 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 (907 KAR 1:671(40)(g)); (10) 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

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	covered medical care, services, or supplies for which a claim is made (907 KAR 1:671(40)(h)); (11) Charging or agreeing to charge or collect a fee from a recipient for covered services that is in addition to amounts paid by the Medicaid Program, except for required copayments or recipient liability, if any, required by the Medicaid Program (907 KAR 1:671(40)(i)); (12) Furnishing medical care, services, or supplies that do not meet professionally recognized standards for health care, e.g., substandard care (907 KAR 1:671.1(40)(k)) (also specifically included in definition of "provider abuse" in KRS 205.8451(8)); (13) Furnishing medical care, services, or supplies that are found to be noncompliant with licensure standards and failing to correct the deficiencies or violation as reported to the HHS Office of Inspector General (907 KAR 1:671.1(40)(k)); (14) Furnishing medical care, services, or supplies that are beyond the scope of the provider's professional qualifications or licensure (907 KAR 1:671.1(40)(k)); (15) "Unbundling," which means to bill separately for each component of a group of procedures that are commonly used together and for which Medicare and/or Medicaid provide a special "bundled" reimbursement rate (907 KAR 1:671.1(40)(p) &(41)); (16) Knowingly failing to meet disclosure requirements, including making false statements to governmental agencies about compliance with any state or federal statutes or regulations (907 KAR 1:671.1(40)(o)); (17) Having payments made through a third party, either directly or by power of attorney, as prohibited by 42 CFR 447.10 regarding reassignments (907 KAR 1:671.1(40)(m)); (18) Offering or providing a premium or inducement to a Medicaid beneficiary in return for the beneficiary's patronage of the provider or other provider to receive medical care, services, or supplies under the Medicaid Program (907 KAR 1:671.1(40)(n)).
LA	*Anti-Kickback Statutes - Fraudulent Remuneration (La. R.S. § 14:70.5)* "Fraudulent remuneration" is the intentional solicitation, receipt, offer, or payment of any remuneration, directly or indirectly, overtly or covertly, in cash or in kind, to or from a third party: (1) in return for referral of an individual to a health care provider for items or services billed to Medicaid; (2) in return for purchasing, leasing, or ordering or for arranging or recommending purchasing, etc. of any item, service, or facility billed to Medicaid; (3) for the recruitment of new patients for any item, service, or facility billed to Medicaid; or (4) to a recipient for any item, service, or facility furnished to the recipient and billed to Medicaid. Practices exempt under the safe harbors set forth in applicable law are not violations. Violation can result in imprisonment of up to five years and/or a fine of up to $20,000.
LA	*Illegal Remuneration (La. R.S. § 46:438.2)* No person shall solicit, receive, offer, or pay any remuneration, directly or indirectly, overtly or covertly, in cash or in kind: (1) in return for referring an individual to a health care provider for items or services reimbursed by Medicaid; (2) in return for purchasing, leasing, or ordering or for arranging or recommending purchasing, etc. any item, service, or facility reimbursed by Medicaid; (3) to a recipient of any item or service reimbursed by Medicaid; or (4) to obtain a recipient list, name, or other

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	identifying information. Protection is provided under safe harbors for discounts and amounts paid to employees and safe harbors created by federal and state laws and regulations.
LA	*Medicaid Fraud (La. R. S. § 14:70.1)* Medicaid fraud is the act of any person who, with intent to defraud the state through the Medicaid program: (1) presents for payment any false or fraudulent claim; (2) knowingly submits false information to obtain greater compensation than that to which he/she is entitled; or (3) knowingly submits false information to obtain authorization for furnishing items or services.
LA	*Medicaid False Claims Statute (La.R.S. § 46:438.3)* No person shall: (1) knowingly present or cause to be presented a false or fraudulent claim; (2) knowingly engage in misrepresentation or make, use, or cause to be made or used, a false record or statement material to a false or fraudulent claim; (3) knowingly make, use, or cause to be made or used, a false record or statement material to an obligation to pay or transmit money or property to Medicaid, or to knowingly conceal, avoid, or decrease an obligation to pay or transmit money or property to Medicaid; (4) conspire to defraud, or attempt to defraud, Medicaid through misrepresentation or by obtaining or attempting to obtain payment for a false or fraudulent claim; or (5) knowingly submit a claim for goods, services, or supplies that were medically unnecessary or of substandard quality or quantity. Violations are punishable by imposition of civil monetary penalties and denial or revocation of provider enrollment.
LA	*Insurance Fraud (La. R.S. §§ 22:1921-28)* A "fraudulent insurance act" includes any act or omission committed by a person who, knowingly and with intent to defraud, presents or causes to be presented, or prepares with the knowledge or belief that it will be presented, to a self-insured governmental entity any oral or written statement that the person knows to contain materially false information as part of, in support of, denial of, or concerning any fact material to, or conceals any information concerning any fact material to, any claim for payment under such self-insured governmental entity's loss fund or risk pool. A "self-insured governmental agency" is an agency of the state or political subdivision of the state, or an agency thereof, or a consortium of governmental entities that maintains a self- insured loss fund or risk pool. In addition to fraudulent insurance acts, the following acts are punishable as felonies: (1) presenting or causing to be presented any written or oral statement in support or denial of a claim for payment or other benefit pursuant to an insurance policy with knowledge that the statement contains false, incomplete, or fraudulent information concerning any fact or thing material to the claim or insurance policy; (2) assisting, abetting, soliciting, or conspiring to prepare or make any written or oral statement intended to be presented to an insurance company, insured, the Louisiana Department of Insurance, or other party in interest in connection with a claim for payment or other benefit pursuant to an insurance policy with knowledge that the statement contains false, incomplete, or fraudulent information concerning any fact or thing material to such claim or insurance policy; or (3) knowingly and willfully committing health care fraud. "Knowingly and willfully" under (3) means continuing to practice, after written notice to cease

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	such practice from a health care benefit program by certified mail, return receipt requested, except when the health care provider reasonably believes that such practice materially complies with coding and billing standards issued by the American Medical Association, HHS, the Centers for Medicare & Medicaid Services, or the Louisiana Medicaid program.
MD	*Medicaid Fraud (Maryland Criminal Law Article, §§ 8-508, 8-511 through 8-512, 8-516 through 8-517)* This statutory framework applies to the Maryland Medicaid program; insurers, health maintenance organizations (HMOs), managed care organizations (MCOs), health care cooperatives or alliances, or other persons that contract with the Medicaid program to provide health care services reimbursable by the Medicaid program; and their subcontractors (a state "health plan"). These laws prohibit a person who provides to another individual items or services for which payment wholly or partly is or may be made from federal or state funds under a State health plan, from soliciting, offering, making, or receiving a kickback or bribe in connection with providing those items or services or with making or receiving a benefit or payment under a State health plan. The laws also prohibit a person from soliciting, offering, making, or receiving a rebate of a fee or charge for referring another individual to a third person to provide items or services for which payment wholly or partly is or may be made from federal or state funds under a State health plan. Violations of these statutes carry significant criminal penalties depending upon the severity of the violation, civil penalties in an amount not more than three times the amount of the overpayment, in addition to any other penalty provided by law and any right the victim may have to restitution under the Maryland Criminal Procedure Article.
MD	*False Claims Statute (Maryland Health-General Article §§ 2-601 through 2-611)* The Maryland False Claims statute prohibits a person from doing any of the following: (1) Knowingly presenting or causing to be presented a false or fraudulent claim for payment or approval; (2) Knowingly making, using, or causing to be made or used a false record or statement material to a false or fraudulent claim; (3) Conspiring to commit such a violation; (4) Having possession, custody, or control of money or other property used by or on behalf of the state under a State health plan or a State health program and knowingly deliver or cause to be delivered to the state less than all of that money or other property; (5) (a) Being authorized to make or deliver a receipt or other document certifying receipt of money or other property used or to be used by the state under a State health plan or a State health program; and (b) intending to defraud the state or the Department of Health and Mental Hygiene by making or delivering a receipt or document knowing that the information contained in the receipt or document is not true; (6) Knowingly buying or receiving as a pledge of an obligation or debt publicly owned property from an officer, employee, or agent of a State health plan or a State health program who lawfully may not sell or pledge the property;

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	(7) Knowingly making, using, or causing to be made or used, a false record or statement material to an obligation to pay or transmit money or other property to the state; (8) Knowingly concealing, or knowingly and improperly avoiding or decreasing, an obligation to pay or transmit money or other property to the state; or (9) Knowingly making any other false or fraudulent claim against a State health plan or a State health program. In addition to criminal penalties referenced above, the False Claims laws provide for civil penalties of $10,000 per violation plus treble damages. Total civil penalty owed for a violation may not be less than amount of the actual damages. These penalties are in addition to any criminal, civil, or administrative penalties provided under any state or federal statute or regulation.
MN	*Medicaid Fraud (Minn. Statutes 609.466)* This law provides that any person who, with the intent to defraud, presents a claim for reimbursement, a cost report or a rate application, relating to the payment of medical assistance funds pursuant to the state medical assistance program, to the state agency, which is false in whole or in part, is guilty of an attempt to commit theft of public funds and may be sentenced accordingly. Sanctions include termination from the Medicaid program, recovery or withholding of overpayments, imposition of monetary fines and other penalties.
MN	*False Claims Statute (Minn. Statutes 15C.02)* Like the Federal False Claims Act, under this statute, (a) A person who commits any act described in clauses (1) to (7) below is liable to the state or the political subdivision for a civil penalty of not less than $5,500 and not more than $11,000 per false or fraudulent claim, plus three times the amount of damages that the state or the political subdivision sustains because of the act of that person: (1) knowingly presents, or causes to be presented, to an officer or employee of the state or a political subdivision 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 to get a false or fraudulent claim paid or approved by the state or a political subdivision; (3) knowingly conspires to either present a false or fraudulent claim to the state or a political subdivision for payment or approval or makes, uses, or causes to be made or used a false record or statement to obtain payment or approval of a false or fraudulent claim; (4) has possession, custody, or control of public property or money used, or to be used, by the state or a political subdivision and knowingly delivers or causes to be delivered to the state or a political subdivision less money or property than the amount for which the person receives a receipt; (5) is authorized to prepare or deliver a receipt for money or property used, or to be used, by the state or a political subdivision and knowingly prepares or delivers a receipt that falsely represents the money or property; (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

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	(7) knowingly makes or uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the state or a political subdivision.
MS	*Anti-Kickback Statute (Rev. Stat. Mo. §§198.145 and 198.148).* Missouri kickback law prohibits a person from purposely soliciting or receiving any payment, including any kickback, bribe or rebate, directly or indirectly, overtly or covertly, in cash or in kind, from any vendor or health care provider and it prohibits any vendor or health care provider from purposely offering or making any such payment if the solicitation or receipt is made in return for or the offer or payment is made to induce: (1) referral of an individual to a person for the furnishing or arranging for the furnishing of any item, or (2) the purchase, lease, order or arranging for the purchase, lease or order of any good, facility, service or item, where payment for (1) or (2) may be made in whole or in part under Medicaid. Penalties include: (1) guilty of a Class D felony; (2) those criminally convicted are prohibited from future participation in Medicaid, subject to reinstatement for good cause shown; and (3) civil liability to the state for all Medicaid moneys obtained as a result of the violation.
MS	*False Claims Statute (Rev. Stat. Mo. § 191.905)* Missouri's false claims statute is similar to the Federal False Claims Act and provides that "no health care provider shall knowingly make or cause to be made a false statement or false representation of a material fact in order to receive a health care payment, including but not limited to: (1) presenting to a health care payer a claim for a health care payment that falsely represents that the health care for which the health care payment is claimed was medically necessary, if in fact it was not; (2) concealing the occurrence of any event affecting an initial or continued right under a medical assistance program to have a health care payment made by a health care payer for providing health care; (3) concealing or failing to disclose any information with the intent to obtain a health care payment to which the health care provider or any other health care provider is not entitled, or to obtain a health care payment in an amount greater than that which the health care provider or any other health care provider is entitled; (4) presenting a claim to a health care payer that falsely indicates that any particular health care was provided, if in fact health care of lesser value than that described in the claim was provided. Any person who violates the state false claims act shall be guilty of a class C felony upon his/her first conviction and shall be guilty of a class B felony upon any subsequent convictions. In addition, any person convicted of a violation of those subsections shall (i) make restitution to the federal and state governments, in an amount at least equal to that unlawfully paid to or by the person, and shall be required to reimburse the reasonable costs attributable to the investigation and prosecution of such violation and (ii) pay a civil penalty of not less than five thousand dollars and not more than ten thousand dollars per violation.

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MS	*False Statements (Rev. Stat. Mo. 198.142)* Under this state law, a health care provider or vendor shall not knowingly: (1) make or cause to be made any false statement or representation of a material fact (i) in any application for any benefit or payment under Medicaid for services provided to any resident or (ii) for use in determining the person's eligibility for any benefit or payment under Medicaid for services provided to any resident; (3) conceal or fail to disclose any material fact that affects its eligibility for any benefit or payment under Medicaid for services provided to any resident or affects the eligibility of another for whom it applies or for whom it receives such benefit or payment, with the intent to secure the benefit or payment in a greater quantity than is due or to secure the benefit or payment when none is permitted; or (4) convert a benefit or payment it receives under Medicaid for services provided to a resident for a use or benefit other than that for which it was specifically intended. Penalties for violations of this statute include: (1) guilty of a Class D felony; (2) those criminally convicted are prohibited from future participation in Medicaid, subject to reinstatement for good cause shown; and (3) civil liability to the state for all Medicaid moneys obtained as a result of the violation.
MS	*Insurance Fraud (Rev. Stat. Mo. 375.991)* A person commits a "fraudulent insurance act" if such person knowingly presents, causes to be presented, or prepares with knowledge or belief that it will be presented, to or by an insurer, any oral or written statement including computer generated documents as part of, or in support of, an application for the issuance of, or the rating of, an insurance policy for commercial or personal 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 material fact or if such person conceals, for the purpose of misleading another, information concerning any material fact. "Statement" means any communication, notice statement, proof of loss, bill of lading, receipt for payment, invoice, account, estimate of damages, bills for services, diagnosis, prescription, hospital or doctor records, x-rays, test results or other evidence of loss, injury or expense. A fraudulent insurance act for a first offense is a class D felony, and any person who is found guilty shall be ordered by the court to make restitution to any person or insurer for any financial loss sustained from such violation. Any subsequent offense shall be a class C felony.
MS	*Additional Sanctions (13 CSR 70-3.030)* A Medicaid provider is subject to sanctions, including loss of Provider-status, for committing or engaging in any of the following acts: (i) presenting for payment any false claim for services under MO HealthNet/Medicaid, (ii) submitting false information to obtain greater compensation than what is permitted under MO HealthNet/Medicaid, (iii) submitting false information on an application for provider-status or (iv) violating any laws of the State of Missouri or the federal government which involve an element of fraud or dishonesty.

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NV	*Anti-Kickback Statute (Nevada Rev. Stat. 422.560)* This statute provides that a provider of health care (or anyone acting on a provider's behalf) may not (i) "offer, transfer or pay anything of value" in connection with the referral of a worker's compensation or Medicaid patient, or (ii) solicit or accept anything of "additional value" when purchasing, selling or leasing goods, materials or supplies for which payment may be made under the State's industrial insurance system or Medicaid plan. A violation is punishable as a gross misdemeanor if the value is less than $250, and as a category D felony if it is more. A category D felony carries a minimum term of 1 year and a maximum term of not more than 4 years, plus a fine of not more than $5,000.
NV	*False Claims Statute (Nevada Rev. Stat. 357.010 – 250)* Nevada's False Claims Statute provides that a person who, with or without specific intent to defraud, does any of the following listed acts is liable for three times the amount of damages sustained, the costs of a civil action and for a civil penalty of not less than $2,000 or more than $10,000 for each act: (a) Knowingly presents or causes to be presented a false claim for payment or approval. (b) Knowingly makes or uses, or causes to be made or used, a false record or statement to obtain payment or approval of a false claim. (c) Conspires to defraud by obtaining allowance or payment of a false claim. (d) Has possession, custody or control of public property or money and knowingly delivers or causes to be delivered to the State or a political subdivision less money or property than the amount for which he receives a receipt. (e) Is authorized to prepare or deliver a receipt for money or property to be used by the State or a political subdivision and knowingly prepares or delivers a receipt that falsely represents the money or property. (f) Knowingly buys, or receives as security for an obligation, public property from a person who is not authorized to sell or pledge the property. (g) Knowingly makes or uses, or causes to be made or used, a false record or statement to conceal, avoid or decrease an obligation to pay or transmit money or property to the State or a political subdivision. (h) Is a beneficiary of an inadvertent submission of a false claim and, after discovering the falsity of the claim, fails to disclose the falsity to the State or political subdivision within a reasonable time. Under Nevada's False Claims Act, employers are prohibited from forbidding employees from making disclosures, testifying or acting in furtherance of an action relating to a false claim under the Act, and from taking any retaliatory action against an employee for such disclosures or actions. Employers may not discharge, demote, suspend, threaten, harass, deny promotion to or otherwise discriminate against an employee in the terms or conditions of his employment because of any such acts. An affected employee may bring a civil action for reinstatement with the same seniority as if the discrimination had not occurred, or damages in lieu of reinstatement if appropriate, twice the amount of lost compensation, interest on the lost compensation, any special damage sustained as a result of the discrimination and

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	punitive damages if appropriate. The employer is also liable for litigation expenses, costs and attorney's fees. Under this statute, a person who makes a claim or causes it to be made, knowing the claim to be false, in whole or in part, by commission or omission for use in obtaining or seeking to obtain authorization to provide specific goods or services, or for use in qualifying as a provider, is guilty of a Category D felony if the amount of the claim or the value of the goods or services obtained or sought to be obtained was greater than or equal to $250. A category D felony carries a minimum term of 1 year and a maximum term of not more than 4 years, plus a fine of not more than $5,000. In addition, the provider is liable in a civil action for an amount equal to three times the amount unlawfully obtained; not less than $5,000 for each false claim; an amount equal to three times the total of the reasonable expenses incurred by the State in bringing suit; and interest. The statute specifically provides (1) that a provider who unknowingly accepts a payment in excess of the amount to which he is entitled is only liable for the repayment of the excess amount, and (2) that it is a defense to an action that the provider returned or attempted to return the amount which was in excess of that to which he was entitled within a reasonable time after receiving it.
NJ	*Anti-Kickback Statute (N.J.S.A. 30:4D-17(c))* This statute generally prohibits any provider, or any person, firm, partnership, corporation or entity who solicits, offers, or receives any kickback, rebate or bribe in connection with: (1) The furnishing of items or services for which payment is or may be made in whole or in part under Medicaid; or (2) the furnishing of items or services whose cost is or may be reported in whole or in part in order to obtain benefits or payments under Medicaid shall be liable to a penalty of not more than $10,000.00 or to imprisonment for not more than 3 years or both.
NJ	*Insurance Fraud (N.J.S.A. 17:33A-1)* A person or practitioner violates this Act if he or she presents or causes to be presented any written or oral statement as part of, or in support of or opposition to, a claim for payment or other benefit pursuant to an insurance policy, knowing that the statement contains any false or misleading information concerning any fact or thing material to the claim. The Act prohibits additional conduct pertaining to insurance claims and insurance applications. In addition to the civil penalties, this Act provides that insurers damaged as a result of a violation of this Act may sue to recover compensatory damages which shall include reasonable investigation expenses, costs of the litigation and attorney fees. Further, this Act also permits an insurer to seek treble damages if a court determines that the defendant in an action brought by the insurer engaged in a pattern of violating the statute. Criminal penalties are available under N.J.S.A. 2C:21-4.4 (et seq.), which provides criminal penalties for the crime of insurance fraud if a person knowingly makes, or causes to be made, a false, fictitious, fraudulent, or misleading statement of material fact in, or omits a material fact from, or causes a material fact to be omitted from, any record, bill, claim or other document, in writing, electronically, orally or in any other form, that a person attempts to submit, submits, causes to be submitted, or attempts to cause to be submitted as part of, in support of, or opposition to or in connection with: (1) a claim for payment, reimbursement or

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	other benefit pursuant to an insurance policy, (2) an application to obtain or renew an insurance policy; (3) any payment made or to be made in accordance with the terms of an insurance policy or premium finance transaction; or (4) an affidavit, certification, record or other document used in any insurance or premium finance transaction.
NJ	*Health Care Claims Fraud Act (N.J.S.A. 2C:21-4.2 and 4.3, N.J.S.A. 2C:51-5 and N.J.S.A. 2C:52-27.1)* These statutes provide for criminal penalties for any person who makes, causes to be made, a false, fictitious, fraudulent, or misleading statement of material fact in, or omitting a material fact from, or causing a material fact to be omitted from, any record, bill, claim or other document, in writing, electronically or in any other form, that a person attempts to submit, submits, or causes to be submitted, or attempts to cause to be submitted for payment or reimbursement for health care services.
NJ	*New Jersey False Claims Act (N.J.S.A., 2A:32C-1)* This law provides a civil penalty of not less than and not more than the civil penalty allowed under the federal False Claims Act for each false or fraudulent claim, plus three times the amount of damages that the State of New Jersey sustained because of the act of that person, if the person commits any of the following acts: (1) Knowingly presents or causes to be presented to an employee, officer or agent of the State of New Jersey, or to any contractor, grantee or other recipient of State funds, 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 to get a false or fraudulent claim paid or approved by the State of New Jersey; (3) Conspires to defraud the State by getting a false or fraudulent claim allowed or paid by the State of New Jersey; and (4) Has possession, custody or control of public property or money used or to be used by the State of New Jersey and knowingly delivers or causes to be delivered less property than the amount for which the person receives a certificate or receipt.
NM	*Anti-Kickback Statutes (NM Statutes § 30-41-1 and § 30-41-2)* Under these laws, it is unlawful to knowingly solicit or receive, or pay or offer to pay, any remuneration in the form of any kickback, bribe, or rebate, directly or indirectly, overtly or covertly, in cash or in kind from a person: (a) in return for referring an individual to that 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 with public money; or (b) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any goods, facilities, services, or items for which payment may be made in whole or in part with public money. A violation is punishable as a fourth degree felony.
NM	*Medicaid Fraud Statutes* A. Medicaid fraud consists of paying, soliciting, offering or receiving: (a) a kickback or bribe in connection with the furnishing of treatment, services or goods for which payment is or may be made in whole or in part under the program, including an offer or promise to, or a solicitation or acceptance by, a health care official or anything of value with intent to influence a decision or commit a fraud affecting a state or federally funded or mandated managed

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	health care plan; (b) a rebate of a fee or charge made to a provider for referring a recipient to a provider; (c) anything of value, intending to retain it and knowing it to be in excess of amounts authorized under the program, as a precondition of providing treatment, care, services or goods or as a requirement for continued provision of treatment, care, services or goods; or (d) anything of value, intending to retain it and knowing it to be in excess of the rates established under the program for the provision of treatment, services or goods. Whoever commits Medicaid fraud as described in this section is guilty of a fourth degree felony. Whoever commits Medicaid fraud when the fraud results in physical or psychological harm to a recipient is guilty of a fourth degree felony; if the fraud results in "great" physical or psychological harm, the penalty is a third degree felony; and if the fraud results in death, the penalty is a second degree felony. If the fraud is committed by an entity rather than an individual, the entity shall be subject to a fine of not more than 50,000 dollars for each misdemeanor and not more than 250,000 for each felony. (NM Statutes § 30-44-7(1)). B. Medicaid fraud also consists of 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. The possible criminal penalty imposed for committing Medicaid fraud as described in this section depends on the value of the benefit, treatment, services or goods improperly provided. The possible resulting penalty ranges from a petty misdemeanor to a second degree felony. If the fraud results in physical or psychological harm, the crime is a fourth degree felony; if the fraud results in "great" physical or psychological harm, the penalty is a third degree felony; and if the fraud results in death, the penalty is a second degree felony. If the fraud is committed by an entity rather than an individual, the entity shall be subject to a fine of not more than 50,000 dollars for each misdemeanor and not more than 250,000 for each felony. (NM Statutes § 30-44-7(2)). C. It is Medicaid fraud to present or cause 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. Whoever commits Medicaid fraud as described in this section is guilty of a fourth degree felony. Whoever commits Medicaid fraud when the fraud results in physical or psychological harm to a recipient is guilty of a fourth degree felony; if the fraud results in "great" physical or psychological harm, the penalty is a third degree felony; and if the fraud results in death, the penalty is a second degree felony. If the fraud is committed by an entity rather than an individual, the entity shall be subject to a fine of not more than 50,000 dollars for each misdemeanor and not more than 250,000 for each felony. (NM Statutes § 30-44-7(3)).

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NM	*False Claims Statutes (NM Statutes § 27-14-4)* Under New Mexico Medicaid False Claims Act, a person commits an unlawful act if the person: (a) presents, or causes to be presented, to the state a claim for payment under the Medicaid program knowing that such claim is false or fraudulent; (b) presents, or causes 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; (c) makes, uses or causes to be made or used 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; (d) conspires to defraud the state by getting a claim allowed or paid under the Medicaid program knowing that such claim is false or fraudulent; (e) makes, uses or causes to be made or used a record or statement to conceal, avoid or decrease an obligation to pay or transmit money or property to the state, relative to the Medicaid program, knowing that such record or statement is false; (f) knowingly applies for and receives a benefit or payment on behalf of another person, except pursuant to a lawful assignment of benefits, under the Medicaid program and converts that benefit or payment to his own personal use; (g) knowingly makes 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; or (h) knowingly makes a claim under the Medicaid program for a service or product that was not provided. A person committing an unlawful act under this section shall be liable to the state for three times the amount of damages that the state sustains as a result of the act.
NY	*New York False Claims Act (State Finance Law, §§ 187-194)* The New York False Claims Act is similar to the federal False Claims Act. It imposes penalties and fines upon individuals and entities who knowingly file false or fraudulent claims for payment from any state or local government, including health care programs such as Medicaid. It also has a provision regarding reverse false claims similar to the federal FCA such that a person or entity will be liable in those instances in which the person obtains money from a state or local government to which he may not be entitled, and then uses false statements or records in order to retain the money. The penalty for filing a false claim under New York's statute is $6,000 to $12,000 per claim plus three times the amount of the damages which the state or local government sustains because of the act of that person. Like the federal False Claims Act, the New York False Claims Act also allows private parties to bring an action on behalf of the state. These private parties, known as "qui tam relators," may share in a percentage of the proceeds from a False Claims Act action or settlement. The state False Claims Act also contains provisions (State Finance Law § 191) that provide protection to employees who are fired, demoted, suspended, threatened, harassed or discriminated against in any manner in connection with their employment because of such employee's participation or involvement in an action brought under the New York False Claims Act. Such employee shall be entitled to the relief necessary to make the employee whole, which may include: (1) injunctive relief; (2) reinstatement of the employee to the same or equivalent position he or she would have had but for the discrimination; (3) reinstatement of

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	full fringe benefits and seniority rights; (4) payment of two times back pay, plus interest; or (5) compensation for any special damages, including litigation costs and attorneys' fees.
NY	*False Statements (Social Services Law § 145-b)* This state law makes it illegal for any person to knowingly obtain or attempt to obtain payment for items or services furnished under any Social Services program, including Medicaid, by use of a false statement, deliberate concealment or other fraudulent scheme or device. The state or the local Social Services district may recover three times the amount incorrectly paid. In addition, the Department of Health may impose a civil penalty of up to $10,000 per violation. If repeat violations occur within five years, a penalty of up to thirty thousand dollars per violation may be imposed if the repeat violations involve more serious violations of Medicaid rules, billing for services not rendered, or providing excessive services. The statute also imposes criminal penalties, and any person who submits false statements or deliberately conceals material information in order to receive public assistance, including Medicaid, is guilty of a misdemeanor.
NY	*Social Services Law § 366-b* This state law prohibits false claims in the New York Medicaid program and makes it a crime for any person who, (1) with intent to defraud, presents for allowance or payment any false or fraudulent claim for furnishing services or merchandise, (2) knowingly submits false information for the purpose of obtaining greater compensation than that to which he is legally entitled for furnishing services or merchandise, or (3) knowingly submits false information for the purpose of obtaining authorization for furnishing services or merchandise under the Medicaid program. A violation of the statute is a class A misdemeanor for which imprisonment from fifteen (15) days to one (1) year may apply. If the underlying act constitutes a violation of another section of the New York Penal Law, however, "the penalties fixed by such law" apply.
NY	*Anti-Kickback Statute (Social Services Law § 366-d)* The statute applies to all providers in the New York Medicaid program and prohibits medical assistance providers from soliciting, receiving, accepting or agreeing to receive or accept or offer, agree to give or give any payment or other consideration in any form from another person to the extent such payment or other consideration is given: (i) for the referral of services for which payment is made under title eleven of article five of this chapter; or (ii) to purchase, lease or order any good, facility, service or item for which payment is made under the Medicaid program. While the statute does not enumerate any "safe harbors," subsection 2(d) specifically states that the prohibition "shall not apply to any activity specifically exempt by federal statute or federal regulations promulgated there under." This language appears to incorporate all of the statutory exceptions and safe harbors available under 42 U.S.C. § 1320a-7b and 42 C.F.R § 1001.952 (federal anti-kickback safe harbors). A violation of the statute is either a misdemeanor or felony depending upon whether the defendant obtains money and/or property in violation of the statute and, if so, the amount obtained.

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NY	*Social Services Law § 366-f* The statute provides that no person acting in concert with a Medicaid provider may solicit, receive, accept or agree to receive or accept or offer, agree to give or give any payment or other consideration in any form from another person to the extent such payment or other consideration is given: (i) for the referral of services for which payment is made under the Medicaid program; or (ii) to purchase, lease or order any good, facility, service or item for which payment is made under the Medicaid program. The statute specifically exempts from the prohibition any activity exempt by federal statute or regulation. A violation of the statute is a misdemeanor punishable by imprisonment or a fine of $10,000 or double the amount of gain attributable to the violation. If the violation results in the individual obtaining money or funds in excess of $7,500, such violation is a class E felony.
NY	*18 N.Y.C.R.R. § 515.2* This regulation prohibits certain "unacceptable practices" in connection with the New York Medicaid program. An "unacceptable practice" is generally defined as conduct which is contrary to: (1) the official rules and regulations of the Department of Health; (2) the published fees, rates, claiming instructions or procedures of the Department of Health; (3) the official rules and regulations of the Departments of Health, Education and Mental Hygiene, including the latter department's offices and divisions, relating to standards for medical care and services under the program; or (4) the regulations of the Federal Department of Health and Human Services promulgated under title XIX of the Social Security Act. This regulation further provides that an "unacceptable practice" is conduct which constitutes fraud or abuse and includes certain specifically enumerated practices. Those unacceptable practices relating to false claims and false statements, kickbacks, unacceptable record keeping and failure to meet standards, include: (1) false claims; (2) false statements; (3) failure to disclose any event affecting the right to payment with the intention that a payment be made when not authorized or in a greater amount than due; (4) converting a medical assistance payment to a use or benefit other than the use and benefit for which it was intended by the medical assistance program; (5) bribes and kickbacks; (6) unacceptable recordkeeping; (7) employment of sanctioned persons; (8) seeking or receiving payment in addition to the amount payable under the program for services rendered; (9) client deception; (10) conspiracy to defraud the Medicaid program; (11) excessive services; (12) failure to meet recognized standards; (13) unlawful discrimination; (14) factoring; (15) solicitation of clients; (16) failure to verify Medicaid eligibility; and (17) denial of services based on inability to pay the copayment. The penalties for violations of any of the various provisions of this regulation include exclusion from the Medicaid program, censure, conditional or limited participation in the program and/or recoupment of overpayments made in connection with a violation.

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NY	*Penal Law § 177.00* Article 177 of the New York Penal Law contains provisions defining varying levels of health care fraud. Generally, a person (including an individual or entity) commits health care fraud when he or she, with intent to defraud a health plan (including Medicaid or a private health plan), knowingly and willfully provides materially false information or omits material information for the purpose of requesting payment from a health plan and as a result, receives payment that he or she is not entitled to under the circumstances. Health care fraud in the fifth degree is a class A misdemeanor. Health care fraud in the fourth degree occurs when the amount involved from a single health plan exceeds $3,000 in one year and is a class E felony. Health care fraud in the third degree occurs when the amount involved from a single health plan exceeds $10,000 in a year and is a class D felony. Second degree health care fraud occurs when the amount involved exceeds $50,000 in one year and is a class C felony. First degree health care fraud occurs when the amount involved from a single health plan exceeds $1,000,000 in one year and is a class B felony.
NY	*Penal Law § 176* Article 176 of the New York Penal Law contains provisions defining varying levels of insurance fraud relating to insurance payments, including Medicaid or other health insurance. Insurance fraud in the fifth degree is a class A misdemeanor. Insurance fraud in the fourth degree occurs when the claim involves an amount in excess of $1,000 and is a class E felony. Insurance fraud in the third degree occurs when the claim involves an amount in excess of $3,000 and is a class D felony. Second degree insurance fraud occurs when the claim involves an amount in excess of $50,000 and is a class C felony. First degree insurance fraud occurs when the claim involves an amount in excess of $1,000,000 and is a class B felony.
NC	*False Claims Statute (N.C. Gen. Stat. §§ 108A-70.10 – 70.16)* This statute prohibits any provider of medical assistance under the Medical Assistance Program from knowingly presenting, or causing to be presented, a false or fraudulent claim for payment or approval, or knowingly making, using, or causing to be made or used a false record or statement to get a false or fraudulent claim paid or approved. Liability to the State or a political subdivision for each violation is between $5,000 and $10,000, plus treble damages for each false claim, costs of the civil action, interest on damages, and costs of the investigation. Penalties may be reduced to not less than two times the amount of damages if the provider cooperates with the fraud investigation. Intent to repay or any actual repayment is not a defense, but it can be considered in mitigation of the penalties assessed.
NC	*Medicaid Fraud (N.C. Gen. Stat. § 108A-63)* This statute defines provider fraud as knowingly and willfully making or causing to be made any false statement or representation of a material fact in seeking medical provider assistance, or knowingly and willfully concealing or failing to disclose any fact affecting entitlement to payment or the amount of payment. Violation of the statute is a Class I felony.

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NC	*False Statements (N.C. Gen. Stat. § 108A-39)* The North Carolina statutes also make it unlawful for any person (including a corporation or other entity), whether provider or recipient of public assistance, who willfully and with the intent to deceive, makes a false statement or representation or who fails to disclose a material fact and as a result obtains or attempts to obtain for himself or another person public assistance. If the public assistance in question is in an amount of not more than four hundred dollars, the act will be classified as a class I misdemeanor. If the amount of public assistance is greater than four hundred dollars, the actor will be guilty of a class I felony.
NC	*Insurance Fraud (N.C. Gen. Stat. § 58-2-161)* The North Carolina Insurance Code criminalizes general insurance fraud. Any person who, with the intent to injure, defraud or deceive an insurer or insurance claimant, engages in the following activities is subject to criminal penalties. The activities include: (i) presenting or causing to be presented a written or oral statement, in support of or in opposition to a claim for payment or other benefit pursuant to an insurance policy, knowing that the statement contains false or misleading information concerning any material fact; or (ii) assisting, abetting, soliciting or conspiring with another person to prepare or make any written or oral statement that is intended to be presented to an insurer or insurance claimant in connection with, in support of, or in opposition to, a claim for payment or other benefit pursuant to an insurance policy, knowing that the claim contains false or misleading information material to the claim.
NC	*Administrative Sanctions (Title 10A North Carolina Administrative Code § 22F.0601 et seq.)* North Carolina administrative regulations provides for administrative sanctions and recoupment for improper payments made to providers by the Medicaid Program. In addition to recoupment, provides for the following administrative sanctions: warning letters; suspension or termination from further participation in the Medicaid Program; and probation. Also includes the following remedial measures: placing a provider on "flag" status, whereby his claims are remanded for manual review; and establishing a monitoring program not to exceed one year. Factors considered in the kind and extent of sanctions include: seriousness of offense; number of violations; prior history; prior imposition of sanctions; length of violations; provider's willingness to obey program rules; recommendations by the investigative staff or Peer Review Committees; and effect on health care delivery in the area.
ND	*Anti-Kickback Laws (North Dakota Administrative Code § 75-02-05-04(7))* Providers may not offer or accept a fee, portion of a fee, charge, rebate, or kickback for a Medicaid patient referral.

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ND	*False Claims Laws - North Dakota Century Code § 26.1-04-03(5)* The making of any false entry in any book, report, or statement with intent to deceive any agent or examiner or any public official, or, with like intent, willfully omitting to make a true entry of any material fact pertaining to the business of the person in any book, report, or statement is considered an unfair method of competition and an unfair or deceptive act in the business of insurance.
ND	*North Dakota Administrative Code § 75-02-05-05(2)* Providers may not submit or cause to be submitted false information for the purpose of obtaining greater compensation than that to which the provider is legally entitled under Medicaid.
OH	*Anti-Kickback Statute (Ohio Revised Code § 3999.22)* No person shall knowingly solicit, offer, pay, or receive any kickback, bribe, or rebate, directly or indirectly, in cash or in kind, in return for referring an individual for the furnishing of health care services or goods for which whole or partial reimbursement is or may be made by a health care insurer, except as authorized by the health care or health insurance contract, policy, or plan. Certain statutory exceptions exist including exceptions for deductibles, copayments, etc., discounts, any amount paid within a bona fide legal entity, and any amount paid as part of a bona fide lease, management, or other business contract. A first violation of the statute is a felony of the fifth degree, punishable by a fine of up to $2,500 and imprisonment for a maximum of twelve months, and any subsequent violation is a felony of the fourth degree, punishable by a fine of up to $5,000 and imprisonment for a maximum of eighteen months.
OH	*Medicaid Fraud (Ohio Revised Code § 2913.40)* The statute prohibits a person from knowingly making or causing to be made a false or misleading statement or representation for use in obtaining reimbursement from the Ohio Medicaid Program. The statute also prohibits doing, with a purpose to commit fraud or knowing that the person is facilitating a fraud, any of the following: charge, solicit, accept, or receive for goods or services that the person provides any consideration in addition to the amount of reimbursement under the Ohio Medicaid Program and the person's provider agreement for the goods or services and any cost-sharing expenses authorized by law; or solicit, offer, or receive any remuneration, other than any cost-sharing expenses authorized by law, 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 Ohio Medicaid Program.

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OH	*Provider Fraud (Ohio Revised Code § 5164.35)* Under this law, no Medicaid provider shall do any of the following: (a) By deception, obtain or attempt to obtain payments under the Medicaid program to which the provider is not entitled pursuant to the provider's provider agreement, or the rules of the federal government or the Medicaid director relating to the program; (b) Willfully receive payments to which the provider is not entitled; (c) Willfully receive payments in a greater amount than that to which the provider is entitled; (d) Falsify any report or document required by state or federal law, rule, or provider agreement relating to Medicaid payments. Any Medicaid provider who violates the above provisions shall be liable, in addition to any other penalties provided by law, for all of the following civil penalties: (1) Payment of interest on the amount of the excess payments at the maximum interest rate allowable for real estate mortgages under section 1343.01 of the Revised Code on the date the payment was made to the provider for the period from the date upon which payment was made, to the date upon which repayment is made to the state; (2) Payment of an amount equal to three times the amount of any excess payments; (3) Payment of a sum of not less than five thousand dollars and not more than ten thousand dollars for each deceptive claim or falsification; (4) All reasonable expenses which the court determines have been necessarily incurred by the state in the enforcement of this law. Further, upon the conviction of, or the entry of a judgment in either a criminal or civil action against, a Medicaid provider, the Medicaid director shall terminate the provider's provider agreement and stop payment to the provider for Medicaid services rendered from the date of conviction or entry of judgment.
OH	*Insurance Fraud (Ohio Revised Code § 2913.47)* This statute prohibits presenting or causing presentation, or assisting, aiding, or conspiring with another to present or cause presentation, to an insurer any written or oral statement that is part of or in support of an application for insurance, a claim for payment pursuant to a policy, or a claim for any other benefit pursuant to a policy, knowing that the statement or any part of it is false or deceptive, with a purpose to defraud or knowing that the person is facilitating a fraud.
OR	*Medicaid Fraud* False Claims (Oregon Revised Statutes 165.690 to 165.698) Under ORS 165.692, "[a] person commits the crime of making a false claim for health care payment when the person: (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." ORS 165.694 provides that "single acts of making a false claim for health care payment may be added together into aggregated counts of making false claims for health care payments if

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	the acts were committed: (a) Against multiple health care payors by similar means within a 30-day period; or (b) Against the same health care payor, or a contractor, or contractors, of the same health care payor, within a 180-day period." Making a false claim for health care payment is a Class C felony punishable by up to 5 years in prison and a fine of up to $125,000.
OR	*Submission of False Claim (Oregon Revised Statues 411.675)* This statute covers false claims for any type of compensation or reimbursement to any public assistance recipient. Liability is limited to the lesser or the amount of payment accepted or the aggregate sum that exceeds the maximum amount payable. However, if the recipient contests the case and is afforded a fair hearing, the recipient may be liable for treble the amount received as a result of the violation. Violation of the statute is a Class C felony.
OR	*Administrative Sanctions (Oregon Administrative Rules 410-120-1510)* This regulation provides authority for the Department of Human services to investigate and respond to substantiated allegations of Fraud and Abuse, including but not limited to suspending or terminating the Provider from participation in the medical assistance programs, withholding payments or seeking recovery of payments made to the Provider, or imposing other Sanctions provided under state law or regulations. Such actions by the Department may be reported to the Centers for Medicare and Medicaid Services, or other federal or state entities as appropriate.
PA	*Anti-Kickback Restrictions (55 Pa. Code § 1101.51)* Medicaid providers are prohibited from making any arrangement with another provider involving the solicitation or receipt or offer of a kickback, payment, gift, bribe or rebate for purchasing, leasing, ordering or arranging for or recommending purchasing, leasing, ordering or arranging for or recommending purchasing, leasing or ordering a good, facility, service or item for which payment is made under the Medicaid program.
PA	*Anti-Kickback Restrictions (62 P.S. § 1407)* It shall be unlawful for any person to: (1) Knowingly or intentionally present for allowance or payment any false or fraudulent claim or cost report for furnishing services or merchandise under medical assistance, or to knowingly present for allowance or payment any claim or cost report for medically unnecessary services or merchandise under medical assistance, or to knowingly submit false information, for the purpose of obtaining greater compensation than that to which he is legally entitled for furnishing services or merchandise under medical assistance, or to knowingly submit false information for the purpose of obtaining authorization for furnishing services or merchandise under medical assistance; or (2) Solicit or receive or to offer or pay any remuneration, including any kickback, bribe or rebate, directly or indirectly, in cash or in kind from or to any person in connection with the furnishing of services or merchandise for which payment may be in whole or in part under the medical assistance program or in connection with referring an individual to a person for the furnishing or arranging for the furnishing of any services or merchandise for which payment may be made in whole or in part under the Medicaid program.

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PA	*False Statements (62 P.S. § 1408)* Under this statute, it is unlawful for any person to: (1) knowingly or intentionally make or cause to be made a false statement or misrepresentation or to willfully fail to disclose a material fact regarding eligibility, including, but not limited to, facts regarding income, resources or potential third-party liability, for either themselves or any other individual, either prior to or at the time of or subsequent to the application for any medical assistance benefits or payments.
PA	*Insurance Fraud (18 Pa. C.S.A. § 4117)* With respect to an insurance benefit or claim covered by this section, a health care provider may not compensate or give anything of value to a person to recommend or secure the provider's service to or employment by a patient or as a reward for having made a recommendation resulting in the provider's service to or employment by a patient; except that the provider may pay the reasonable cost of advertising or written communication as permitted by rules of professional conduct. Upon a conviction of an offense provided for by this paragraph, the prosecutor shall certify such conviction to the appropriate licensing board in the Department of State which shall suspend or revoke the health care provider's license.
TX	*Anti-Kickback Statute (Tex. Hum. Res. Code § 32.039)* Under this law, it is unlawful for a person: (i) to offer to pay or agree to accept, directly or indirectly, overtly or covertly any remuneration in cash or in kind to or from another for securing or soliciting a patient or patronage for or from a person licensed, certified, or registered by a state health care regulatory agency; (ii) to solicit or receive, directly or indirectly, overtly or covertly any remuneration, including any kickback, bribe, or rebate, in cash or in kind for referring an individual to a person for the furnishing of, or for arranging the furnishing of, any item or service for which payment may be made, in whole or in part, under the medical assistance program; (iii) to solicit or receive, directly or indirectly, overtly or covertly any remuneration, including any kickback, bribe, or rebate, in cash or in kind for purchasing, leasing, or ordering, or arranging for or recommending the purchasing, leasing, or ordering of, any good, facility, service, or item for which payment may be made, in whole or in part, under the medical assistance program; (iv) to offer or pay, directly or indirectly, overtly or covertly any remuneration, including any kickback, bribe, or rebate, in cash or in kind to induce a person to refer an individual to another person for the furnishing of, or for arranging the furnishing of, any item or service for which payment may be made, in whole or in part, under the medical assistance program; (v) to offer or pay, directly or indirectly, overtly or covertly any remuneration, including any kickback, bribe, or rebate, in cash or in kind to induce a person to purchase, lease, or order, or arrange for or recommend the purchase, lease, or order of, any good, facility, service, or item for which payment may be made, in whole or in part, under the medical assistance program; or (vi) to provide, offer, or receive an inducement in a manner or for the purpose not otherwise prohibited by this section or section 102.001, Tex. Occupations Code, to or from a person, including a recipient, provider, or employee or agent of a provider, third party vendor, or public servant for the purpose of influencing or being influenced in a decision regarding selection of a provider or receipt of a good or service under the medical assistance program, the use of goods or

State	Description
	services provided under the medical assistance program or the inclusion or exclusion of goods or services available under the medical assistance program. Violations are subject to the following penalties: (i) the amount paid as a result of the violation, including interest; (ii) administrative penalties not to exceed twice the amount paid, plus an amount not less than $5,000.00 and not more than $15,000.00 for each violation; and (iii) exclusion from the Medicaid program for 3 to 10 years depending on the violation.
TX	*Medicaid Fraud - Criminal Violations (Tex. Penal Code § 35A.02)* Under this provision, a person commits the offense of Medicaid Fraud if the person, except as authorized under the Medicaid program, knowingly pays, charges, solicits, accepts, or receives, 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.
TX	*Medicaid Fraud - Civil Violations (Tex. Hum. Res. Code Chapter 36)* A person commits a violation of the Texas Medicaid Fraud Prevention Act if the person: (i) makes a false statement or misrepresents a material fact to obtain a benefit or payment; (ii) conceals an event or fact that affects the initial or continued right to a payment or benefit; (iii) applies for or receives a benefit or payment on behalf of a recipient and converts some or all of the benefit or payment for use other than on behalf of the recipient; (iv) makes, causes to be made, induces or seeks to induce the making of a false statement or misrepresentation regarding the (a) conditions or operation of a facility to obtain certification or recertification or (b) any other information required to be provided to the Medicaid program; (v) accepts or charges any gift, money or other consideration, other than the Medicaid payment, as a condition for the provision of services to a Medicaid recipient; (vi) presents a claim for payment for services rendered by a person who is not licensed; (vii) makes a claim for a service that (a) has not been ordered by an appropriate practitioner, (b) is substandard or inadequate or (c) for a product that has been mislabeled or adulterated; (viii) makes a claim for payment and fails to indicate the type of license or identification number of the provider who actually rendered the services; (ix) enters into a conspiracy to defraud the state by obtaining an unauthorized payment or benefit; (x) knowing engaging in conduct that constitutes a violation of Tex. Hum. Res. Code, Chapter 32; or (xi) knowingly engaging in conduct that constitutes a violation of Tex. Occ. Code, Chapter 102. If a person violates the Act, he or she could be subject to the following: (i) suspension or revocation of the provider agreement, permit, license, or certification; (ii) exclusion from the Medicaid program for a period of no less than ten (10) years; (iii) disciplinary action by a state licensing board; (iv) restitution for the value of any money or benefit received; (v) civil penalty from $5,000.00 to $15,000.00 depending on the unlawful act; and penalties of up to two times the value of the unlawful payment or benefit received.

State	Description
VA	*Anti-Kickback Statute (Va. Code Ann. § 32.1-315)* This statute prohibits the knowing and willful solicitation, receipt, offer or payment of any remuneration, including any kickback, bribe or rebate, directly or indirectly, overtly or covertly, in cash or in kind: (1) to refer or 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 medical assistance; or (2) to purchase lease, order or arrange for or recommend purchasing, leasing or ordering or in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing or ordering any goods, facility, service or item for which payment may be made in whole or in part under medical assistance. Violators will be guilty of a Class 6 felony punishable by either or both a term of imprisonment of not less than one year nor more than five years, or in the discretion of the jury or the court trying the case without a jury, confinement in jail for not more than 12 months and a fine of not more than $2,500. Additionally, a violator may be fined up to $25,000.
VA	*False Claims Statutes - Va. Code Ann. § 8.01-216.3* These statutes prohibits a person from knowingly (either has actual knowledge of the information, acts in deliberate ignorance of the truth or falsity of the information, or acts in reckless disregard of the truth or falsity of the information) making claims for money or property to the Commonwealth (including any agency of state government and any political subdivision of the Commonwealth). No proof of specific intent to defraud is required. Liability to the Commonwealth is for a civil penalty of not less than $5,500 and not more than $11,000, plus three times the amount of damages, and reasonable attorney fees and costs of a civil action for recovery of any penalties or damages. Damages may be reduced if the person cooperates with the fraud investigation. Does not apply to claims, records or statements relating to state or local taxes.
VA	*Va. Code Ann. § 32.1-312* Where the Commonwealth directly or indirectly provides any medical assistance benefits or payments, prohibits any person, agency, or institution from using willful false statements, willful misrepresentations, willful concealment of material facts, or any other fraudulent scheme or device to obtain or attempt to obtain any medical assistance benefits or payments in a greater amount than that to which the person is entitled. This section does not apply to an individual medical assistance recipient of health care. Liability to the Commonwealth is for the amount of any excess benefits or payments plus interest and civil penalties not to exceed three times the amount of the excess benefits or payments.

State	Description
VA	*False Statements - Va. Code Ann. § 18.2-498.3* This statute provides that any person, in any commercial dealing in any matter within the jurisdiction of any department or agency of the Commonwealth of Virginia, or any local government within the Commonwealth or any department or agency thereof, who knowingly falsifies, conceals, misleads, or covers up by any trick, scheme, or device a material fact, or makes any false, fictitious or fraudulent statements or representations, or makes or uses any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry, shall be guilty of a Class 6 felony.
VA	*Va. Code Ann. § 32.1-314* This statute provides that persons shall be guilty of a felony for knowingly and willfully making or causing to be made a false statement for use in any application for any payment under medical assistance or for use in determining rights to such payment, or falsifying or concealing any material fact in connection with such medical assistance application or payment, or, when having knowledge of any event affecting the initial or continued right to any payment, willfully concealing or failing to disclose such an event with the intent of to fraudulently secure such payment either in a greater amount or quantity that is due. Acts are punishable by imprisonment of not less than one nor more than twenty years, or in the discretion of the jury or court sitting without a jury, confinement in jail for not more than twelve months. Guilty persons may also be fined up to $25,000.
WA	*Anti-Kickback Statute (RCW 74.09.240(1) and (2))* This statute prohibits a person, including any corporation, from soliciting, receiving, offering or paying, any remuneration (including any kickback, bribe or rebate) directly or indirectly, overtly or covertly, in cash or in kind in return for or as an inducement to 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 by the Washington Medicaid program. It also prohibits soliciting, receiving, offering or paying any remuneration (including any kickback, bribe or rebate) directly or indirectly, overtly or covertly, in cash or in kind in return for purchasing, leasing, ordering or arranging for or recommending purchasing, leasing, or ordering, any goods, facility, service or item for which payment may be made by the Washington Medicaid program. Violation of the statute is a felony and punishable by a fine of up to $25,000.
WA	*False Claims Statutes - RCW 48.80.030* This statute prohibits a person from making or presenting or causing to be made or presented to a health care payer a claim for a health care payment knowing the claim to be false. It also prohibits a person from knowingly presenting to a health care payer a claim for a health care payment that falsely represents that the goods or services were medically necessary in accordance with professionally accepted standards. It further prohibits a person from knowingly making a false statement or false representation of a material fact to a health care payer for use in determining rights to a health care payment. Each claim that violates the statute is a separate violation.

State	Description
WA	*RCW 74.09.210* A person or entity who obtains or attempts to obtain payment from a state health care benefit program in an amount greater than that to which the person or entity is entitled by means of willful false statements; willful misrepresentation or concealment of any material facts; or any fraudulent scheme (including billing for items or services not provided, misrepresenting the items billed, or billing for purportedly covered items, which were in fact not covered) must repay the amounts wrongfully obtained plus interest and may be subject to a civil penalty in an amount up to three times the amount of the excess payments received.
WA	*RCW 74.09.230* This statute prohibits a person from knowingly making or causing to be made any false statement or representation of a material fact in any application for any payment under any state medical care program. It also prohibits a person from knowingly making or causing to be made any false statement or representation of a material fact for use in determining rights to payment under any state medical care program, or knowingly falsifying, concealing, or covering up by any trick, scheme, or device a material fact in connection with such application or payment. It further prohibits a person having knowledge of the occurrence of any event affecting either the initial or continued right to any payment, or the initial or continued right to any such payment of any other individual in whose behalf he has applied for or is receiving such payment, from concealing or failing to disclose such event with an intent fraudulently to secure such payment either in a greater amount or quantity than is due or when no such payment is authorized. Violation of the statute is a felony punishable by a fine of not more than $25,000.
WA	*RCW 74.66.020* Under this statute, a person is liable to the government entity for a civil penalty of not less than five thousand five hundred dollars and not more than eleven thousand dollars, plus three times the amount of damages which the government entity sustains because of the act of that person, if the 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 one or more of the violations in this subsection (1); (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.

State	Description
WI	*Anti-Kickback Statute (Wis. Stat. 49.49(2))* It is unlawful for any person in connection with a medical assistance program (defined as any services or items provided under the Title XIX program or any payment or reimbursement made for such services or items) to solicit or receive, offer or pay any remuneration, including kickbacks, bribes, and rebates, in return for referring an individual to a person who furnishes items or services for which payment may be made in whole or in part under a medical assistance program. Further, it is unlawful for any person to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service or item which is payable in whole or in part under the medical assistance program. Such remunerations are prohibited whether they are direct or indirect, overt or covert. Violation of this section is a Class H felony, and is punishable by imprisonment not to exceed six years or a fine of not more than $25,000 or both. The prohibition against discounts notwithstanding, a discount or other reduction in price received by an entity (or a provider) that operates a social services program, a program for disabled, or a mental health program will not be considered a kickback or a bribe.
WI	*Medicaid Fraud (Wis. Stat. § 49.49(1))* It is prohibited to commit fraud in connection with a medical assistance program. Fraud includes: (1) the knowing and willful misrepresentation of a material fact in an application for a benefit or payment; (2) a false statement or representation of a material fact that affects the determination of rights to a benefit or payment; (3) concealing or failing to disclose information, affecting the right to a benefit, with the intent to fraudulently secure the benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized; or (4) conversion of a benefit or payment. The statute provides for fines in the amount of not more than $25,000 for a person who is furnishing services for which medical assistance payment is or may be made; and not more than $10,000 or imprisonment for not more than one year for any other person. A conviction could also result in the collection of damages, by the state, in an amount three times the amount of the actual damages sustained by the state.
WI	*False Claims Statute (Wis. Stat. § 20.931)* Any person who does any of the following is liable to this state for 3 times the amount of the damages sustained by this state because of the actions of the person, and shall forfeit not less than $5,000 nor more than $10,000 for each violation: (a) Knowingly presents or causes to be presented to any officer, employee, or agent of this state a false claim for medical assistance; (b) Knowingly makes, uses, or causes to be made or used a false record or statement to obtain approval or payment of a false claim for medical assistance; (c) Conspires to defraud this state by obtaining allowance or payment of a false claim for medical assistance, or by knowingly making or using, or causing to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Medical Assistance program; (d) Knowingly makes, uses, or causes to be made or used a false record or statement to conceal, avoid, or decrease any obligation to pay or transmit money or property to the Medical Assistance program; (e) Is a beneficiary of the submission of a false claim for medical assistance to any officer, employee, or agent of the state, knows

State	Description
	that the claim is false, and fails to disclose the false claim to this state within a reasonable time after the person becomes aware that the claim is false.

Annex B: Reviews and Changes to the Policy

Version	Reason for change	Date
1.0	Created	December 2013
2.0	Revised by FGA Legal	March 2014
3.0	Reviews and amended – reflect implementation of Compliance Program, designation of new Compliance Officer, change controlled and ownership added. Reviewed and approved by Transdev NA Legal.	December 2016
4.0	Updated logo, brand and references to Transdev following the March 6, 2023 acquisition.	December 2023