MEDICAID FRAUD LAWS AND PROPOSALS

SETTING THE RECORD STRAIGHT

Healthcare Association of New York State

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The Governor’s Budget

Included in Governor Spitzer’s budget are sweeping proposals to address Medicaid fraud and abuse. Among other things, the Governor is pressing for enactment of a “Martin Act” for health, a State False Claims Act (FCA), and the enactment of new criminal laws that exceed even those contained in the existing Martin Act. The Governor’s Martin Act legislation parallels the Martin Act as contained in Article 23-A of the General Business Law. The FCA legislation mirrors federal law. The new crimes impose felony sanctions without the need to prove an intent to defraud.

This document describes existing laws and the Governor’s proposals. To provide a meaningful context for the Governor’s initiative, existing fraud laws are examined, including the omnibus legislation that was enacted in 2006—the most sweeping anti-fraud legislative package ever enacted in the state. The myriad federal fraud laws are described, as well as the new federal Medicaid Integrity Program.

HANYS believes that providing a comprehensive overview of the entire landscape of Medicaid fraud laws and initiatives allows for an informed debate on the advisability of enacting the Governor’s proposed legislation. HANYS believes that the gravity of the Governor’s legislation calls for a thorough understanding of the current legal climate. We believe that the Legislature should be provided with the full story, to reach appropriate policy and legal decisions.

The Martin Act

What is the “Martin Act”?

I. Introduction

Originally enacted in 1921 to address the securities industry, the Martin Act still today confers “upon the Attorney General of New York the broadest and most easily triggered investigative and prosecutorial powers of any securities regulator, state or federal.” While several sections of General Business Law Article 23-A comprise the Act, three in particular are at the heart of the law. These three, §§ 352, 352-c, and 353, and contain provisions unequalled in any other New York or federal laws. The first, §352, grants the Attorney General extraordinary investigative
discretion and power. The second, §352-c, contains criminal laws unique to the Martin Act. The third, §353, confers broad prosecutorial power on the Attorney General.

What about the first section on investigations?

II. Section 352 – Investigations by the Attorney General

Section 352 includes several critical elements that merit description in order to understand the near-limitless magnitude of the law.

How are they started?

A. Commencing an Investigation

There are three grounds on which the Attorney General may open an investigation:

- in response to a complaint;
- in response to something other than a complaint; or
- when the Attorney General determines it is in the public interest.

Once the Attorney General decides to open an investigation, he or she may, in his or her sole discretion, direct the person or entity to be investigated to file a statement, under penalty of perjury, as to all the facts and circumstances that the Attorney General deems to be in the public interest.

In addition to requiring a sworn statement, “the Attorney General may also require such other data and information as he may deem relevant and may make such special and independent investigations as he may deem necessary in connection with the matter.” (GBL §352 [1])

The State’s highest court, the Court of Appeals, has held that the Attorney General’s decision to open an investigation is wholly within his or her discretion. In other words, the reasonableness of, or justification for opening an investigation is not subject to judicial review. There is no judicial redress if a person or entity believes it has been unfairly targeted.

The standards for commencing an investigation are exceedingly loose and, as emphasized above, leave the Attorney General with almost limitless discretion to subject people and entities to investigation. Further, judicial decisions over the decades have reinforced the Attorney General’s exclusive authority to begin an investigation solely because the Attorney General “believes” it is in the public interest to do so.
What happens during the course of an investigation?

B. Conduct of an Investigation

Once the investigation is opened, §352 provides the legal parameters within which it must be conducted. The discretionary and absolute powers granted to the Attorney General are enormous.

The Attorney General, or a designated deputy, may subpoena witnesses, “compel their attendance,” and “examine them under oath.” A subpoenaed person who fails to attend the inquiry without reasonable cause, or who refuses to be sworn in, is guilty of a Class A misdemeanor. The subpoenaed person must answer any question and produce “any books or records” that the Attorney General “deems relevant or material to the inquiry.” Unreasonable failure to do so carries the same consequences—criminal prosecution by the Attorney General for a misdemeanor violation.

It’s a crime to refuse to answer a question?

Yes, the Attorney General has the power to criminally prosecute a person who at that point is under investigation, but not charged with any violation. The McKinney’s 2006 Practice Commentary on the Martin Act states:

There is no necessity for the Attorney General to seek an order compelling compliance with a Martin Act subpoena [the traditional method of enforcement]; rather the Attorney General has the power (and has exercised this power on many occasions) to go before a grand jury for an indictment or to otherwise effectuate an arrest of a person who fails to comply with such a subpoena.

What happens to books and records once they’re turned over to the Attorney General?

With regard to the custody of books and records, the Governor’s proposed Martin Act for health care exceeds the existing Martin Act. Specifically, the budget legislation gives the Attorney General the authority to impound books, records “or other evidence” produced during an investigation and retain them in his custody. Once the documents are in the Attorney General’s custody, they cannot be removed without a court order or with the Attorney General’s consent. The practical import of this provision is to deprive individuals under investigation from accessing documents, even their own documents, that may contain valuable evidence to support the person’s position once a prosecution begins.

Taken together, the “books and records” provisions in the current and proposed Martin Act require persons to produce any document as ordered by the Attorney General and allow the Attorney General to keep them.
Where does the questioning of witnesses take place?

As to the site of the examination, the Attorney General has the authority to demand that the witness appear before him or her (or a deputy) in the privacy of the Attorney General’s office. The Attorney General, however, has the discretion to compel the witness’ attendance before a judge in open court. In either setting, the criminal enforcement authority described above applies. In other words, the witness may be questioned in secret in the Attorney General’s office or be put on public display to respond to the Attorney General’s questioning.

But your lawyer may accompany you, correct?

Since §352 governs the conduct or investigations and “examinations” of individuals not yet arrested or indicted for any criminal offence, the courts have held that a witness does not have the right to have the assistance of counsel during the course of the examination, or with regard to the production of books and records. The net result is that a witness is required to attend either a private examination before the Attorney General, or appear in open court, required to answer any question and produce any document without the presence of an attorney.

This law must apply only to people that are actually committing fraud, correct?

C. Subjects of an Investigation

As described above, the Attorney General has complete discretionary authority to open an investigation. The Attorney General may target an investigation on individuals or entities that are not engaging in fraudulent conduct. Subdivision 1 of §352 provides that “Whenever it shall appear to the Attorney General...” A person or corporation shall have employed, or employs, or is about to employ any device... deception, misrepresentation, concealment, suppression... or shall have engaged in or engages in or is about to engage in any practice or transaction which is fraudulent or in violation of law, then the Attorney General may begin the investigation. If it “appears” to the Attorney General that a person is “about to” engage in a “fraudulent activity,” but has not done so, the investigatory and prosecutorial thresholds are triggered.

Even if it covers people who are “about to do” something, the Attorney General can’t investigate people who don’t even intend to engage in fraud, can he?

D. “Intent” Is Not A Necessary Element

Under the Martin Act even the definition of “fraud” or “fraudulent activity” is unequaled in its expanse. The Court of Appeals has stated:

The primary purpose of the (Martin Act) is remedial in its character... The purpose of the law is to prevent all kinds of fraud... and to defeat all unsubstantial and visionary schemes in relation thereto whereby the public is exploited... the words “fraud” and “fraudulent practices” in this connection should, therefore, be given a wide meaning so as to include “all acts, although not originating in any actual evil design or contrivance to
perpetuate fraud or injury upon others, which do by their tendency to deceive or mislead the purchasing public come within the purpose of the law.”

Clearly, the Attorney General need not prove an intent to defraud: instead, the Attorney General may investigate and prosecute when it “appears” that an unintended “fraudulent practice” is “about to be employed.” No intended act need have occurred, no money need change hands, and no ill-gotten gain need be shown in order for the full weight of the Martin Act to be applied. As the Practice Commentary notes: “Specifically, the Martin Act granted to the Attorney General the power to prosecute acts and practices that go beyond actual or intentional fraud.” The Attorney General must only prove that some activity, by its “tendency to deceive” has or is about to occur.

Under the Martin Act, the Attorney General can prosecute crimes. District Attorneys do the same thing, so what difference does it make?

III. Criminal Prosecutions

The legislation submitted by the Governor provides the Attorney General with prosecutorial authority that has few precedents. It allows the Attorney General or a deputy to prosecute any crime or offense “arising from or relating to any [Martin Act] investigation.” The Attorney General, at his own discretion, may “exercise all the powers and perform all the duties” that are otherwise conferred on the state’s criminal prosecutors—local district attorneys.

A third key provision in the budget bill is the waiving of §60.22 of the Criminal Procedure Law. Section 60.22 provides that no person may be convicted of a crime based solely on the testimony of an accomplice—the accomplice’s testimony must be independently corroborated by a non-accomplice. The Governor proposes that this longstanding rule of criminal process be ignored for Martin Act prosecutions. The Governor also proposes a complementary provision allowing the Attorney General to grant immunity from prosecution for key witnesses. Taken together, these proposals mean that the Attorney General may immunize an accomplice and a conviction can occur based solely on the testimony of the immunized accomplice.

As a general matter, the Attorney General has prosecutorial authority. The Governor’s legislation, however, extends the authority to allow the Attorney General to arbitrarily decide to supplant the career criminal prosecutor, the local District Attorney, and prosecute any case relating to a Martin Act investigation.

Equally troubling is the waiver of CPL §60.22. The statute exists because of the dubious validity of accomplice testimony that is often unsubstantiated. It is a codification of centuries-old criminal procedure that simply holds that an accomplice’s assertions must be substantiated in order to convict a person of a crime. Judges, juries, and prosecutors must adhere to the law to avoid false convictions. Yet the Governor proposes that when it comes to an Attorney General prosecution of a Martin Act case, the law is ignored.
The Attorney General under the current Martin Act and in the budget bill has power that vastly exceeds that of a District Attorney. The Attorney General may, for example subpoena individuals, books, and records if the Attorney General deems it “in the public interest.” The Attorney General may demand documents he or she considers material or relevant to an inquiry. Essentially, no formal procedural rules govern the Attorney General’s actions.

Local district attorneys must present a case to a grand jury in order to seek an indictment. To compel the production of witnesses, books and records, the grand jury issues the subpoena. The private citizens on the grand jury must determine if a subpoena is warranted: it is not in the sole and unfettered discretion of the district attorney to do so. Until an “accusatory instrument”, e.g., an indictment is issued, the district attorney works through the grand jury process to order a witness to testify or produce books and records.

Of greater significance is that in the New York courts, witnesses called to testify before a grand jury are given “transactional immunity” regarding the subject matter of the inquiry. This means that if a witness testifies before a grand jury, the person is thereafter immune from prosecution regarding the subject matter of the inquiry. No comparable provision is present in either the current Martin Act or in the Governor’s proposal.

The net result of these prosecutorial provisions is that:

- convictions may be based on no more than unsubstantiated testimony of an immunized accomplice, a deviation from the general statutory standard;
- no process involving the participation of private citizen grand jurors is followed; and
- the immunity protection afforded witnesses testifying before private grand jurors is stripped away.

The current Martin Act includes misdemeanor-level crimes. What about the Governor’s proposal?

IV. New Criminal Laws

The budget legislation would add five new crimes to Article 177 of the Penal Law. They are entitled “Deceptive Health Care Practices,” a Class A misdemeanor; “Scheme to Defraud a Health Care Plan” in the first, second and third degrees, which are Class E, C, and B felonies respectively; and “Aggravated Health Care Fraud,” a Class D felony. The legislation also proposes that a violation of these laws should be punishable more severely than is otherwise the case for Class B, C, D, and E felonies. As a point of comparison third-degree rape is an E felony, second-degree rape is a D felony and first-degree rape is a B felony (Penal Law §§ 125, 130, 135).

The crimes proposed by the Governor largely mirror those contained in the current Martin Act, GBL §352-c. Of significance is that these are not all crimes of intent—if an event occurs, the
crime is committed even if no intent to defraud, for example, was present. The Practice Commentary states:

Accordingly, a long line of cases has consistently established the principle that neither scienter nor intent need to be alleged or proven to sustain civil liability in general, or misdemeanor criminal culpability under §352-c of the Martin Act. Rather, it is held by the judiciary that “fraud” thereunder includes all deceitful practices contrary to the plain rules of common honesty and all acts tending to deceive or mislead the public, whether or not the product of scienter or intent to defraud.

What may be most troubling about the Governor’s proposal is that here again it exceeds the current Martin Act. The “crimes” in Martin Act §352-c are all misdemeanors. The comparable crimes in the Governor’s legislation are all felonies, on a par with the most heinous of crimes. Yet because of the relaxation of the law regarding uncorroborated accomplice testimony, the standard of proof required for a conviction under the Governor’s proposal is more relaxed than for conviction of lesser offenses under the Martin Act.

*Why is a law like the Martin Act even on the books?*

In the late 19th and early 20th centuries, the country was awash in scandal over phony stock offerings, outright lying to an unwitting public and massive public swindling. No federal securities laws existed and the individual states took action to enact their own. These laws were so-called “Blue Sky” laws aimed to end wildly speculative schemes that were grounded in nothing more than “so many feet of blue sky.” The Martin Act is New York’s Blue Sky law, enacted to fill a gaping legal void.

The courts have described the purpose of the law:

*The Martin Act . . . was passed to protect the inexperienced, confiding and credulous investor and save him from his own credulous cupidity . . . it should be given such a broad construction as would put an end to all visionary and fantastic schemes of promoters and the sale and disposition of securities whereby the public would be fraudulently exploited, so far as that might be done.*

By 1925, most states had passed Blue Sky laws, but it was not until 1933 and again in 1934 that the first federal laws were enacted following the 1929 stock market crash.

*That explains why the law is so extreme. When it comes to Medicaid fraud, though, are we talking about the state needing to be protected from its own “credulous cupidity”? Are there “visionary and fantastic schemes”?*

The government of the State of New York is hardly akin to the “inexperienced, confiding and credulous investor” of the early 20th century. The state, unlike the general investing public of 90 years ago, is not so uninformed and gullible that it needs to be “saved” from its own “credulous cupidity” by an intentionally crafted paternalistic law. In 1921, there were no federal securities laws and no state securities laws. Today, we can easily identify nearly 30 federal and state
administrative, civil and criminal laws addressing Medicaid fraud. The conditions under which the original Martin Act was passed and the conditions today have nothing in common.

What power does the Attorney General currently have? It seems that a Martin Act would provide a great deal of authority that is generally lacking. What does the Executive Law currently empower the Attorney General to do?

Section 63 of the Executive Law enumerates the powers and duties of the Attorney General. Two subdivisions are especially relevant.

Subdivision 12 of §63 states that the Attorney General may go to court to obtain an injunction and an order for restitution and damages “whenever any person shall engage in repeated fraudulent or illegal acts or otherwise demonstrate persistent fraud or illegality in the carrying on, conducting or transaction of business.” “Fraud” is defined as any scheme or artifice to defraud and any deception, misrepresentation, concealment, false pretense, or false promise, among other things. Repetition of a fraudulent or illegal act or the continuation of fraudulent activity is considered “repeated and persistent” behavior that invokes the statute. In other words, the Attorney General may prosecute activity if it is fraudulent and occurs repeatedly, e.g., over a series of similarly incorrect claims.

The Attorney General is also provided with extensive power and authority under subdivision 8 of §63. “Whenever in his judgment the public interest requires it,” the Attorney General may inquire into “matters concerning the public peace, public safety and public justice” with the approval, or at the direction of the Governor.

The “inquiry” authority is not an informal process. The Attorney General or a designated deputy may subpoena witnesses, examine them under oath, and compel the production of papers for examination and audit. Subdivision 8 criminalizes non-obedience—if a person refuses to appear, fails to produce all books and records or refuses to answer a question, he/she is guilty of a misdemeanor.

The Attorney General has the authority to decide if the hearing will be held privately before the Attorney General or designated deputy, or in open court before a magistrate. All public officers and “all other persons” have the duty “to render and furnish to the Attorney General, his deputy or other designated officer, when requested, all information and assistance in their possession and within their power.” No one involved in the inquiry as an officer or witness may disclose any witness’ name or information obtained, unless permitted to do so by the Attorney General or the Governor. A violation is a misdemeanor.

Putting the two subdivisions together, it is clear that the Attorney General has wide authority to prosecute fraud “whenever any person shall engage” in the activity. In the course of determining if a person or entity is violating any of the several fraud-fighting laws, the Attorney General may open an “inquiry” “whenever in his judgment the public interest requires it.” The only check on this authority is that the Governor must at least approve of the opening of the investigation. The conduct and breadth of the investigation, however, is left largely in the Attorney General’s
hands; the law is intentionally written to give the state’s chief law enforcement officer wide latitude to pursue wrongdoing.

The grant of authority already in statute raises the question of why New York needs another Martin Act at all. It is difficult to imagine how an Attorney General could think that the provisions in the Executive Law are not enough. The obvious corollary question is whether the “limitations” in current law have prevented the bringing of legitimate cases that a Martin Act would allow.

**Existing New York Laws**

*Aren’t there already plenty of laws that deal with Medicaid fraud, unlike the situation with securities in the 1920s when there were no state or federal laws?*

Yes, of course. New York fraud and false claims laws fall into two categories: administrative and civil laws; and criminal laws. Many of them overlap. Some apply to recipient false claims and some apply to provider false claims, and while most are specific to healthcare or Medicaid, some of the “common law” crimes apply to all walks of life. The following list is not exhaustive but identifies most of the significant state anti-fraud laws.
I. Administrative and Civil Laws

1. Social Services Law §145-c If any person applies for or receives public assistance, including Medicaid, by intentionally making a false or misleading statement, or intending to do so, the person’s, the person’s family’s needs are not taken into account for six months if a first offense, 12 months if a second (or once if benefits received are $1,000-$3,900), 18 months if a third (or once if benefits received are over $3,900) and five years for four or more offenses.

2. Social Services Law §145-b - False Statements It is a violation 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 (DOH) may impose a civil penalty of up to $2,000 per violation. If repeat violations occur within five years, a penalty up to $7,500 per violation may be imposed if they involve more serious violations of Medicaid rules, billing for services not rendered or providing excessive services.

3. Public Health Law Article II, Title 2-D Commonly known as the “State Stark” law, §§ 238 – 238-e prohibit a physician from making referrals to an entity in which the physician has a financial interest if the entity provides “designated health services.” A financial interest includes a compensation arrangement or an investment interest in the entity. The law contains several exceptions to the general prohibition which, if followed, allow the arrangement to operate. A violation of the State Stark Law is punishable by the imposition of civil penalties as prescribed in §§ 12 and 12-b of the Public Health Law.

II. Criminal Laws

1. Social Services Law §145, Penalties. Any person who submits false statements or deliberately conceals material information in order to receive public assistance, including Medicaid, is guilty of a misdemeanor.

2. Social Services Law §366-b, Penalties for Fraudulent Practices

   a. Any person who obtains or attempts to obtain, for himself or others, medical assistance by means of a false statement, concealment of material facts, impersonation or other fraudulent means is guilty of a Class A misdemeanor.

   b. Any person who, with intent to defraud, presents for payment any false or fraudulent claim for furnishing services, knowingly submits false information to obtain greater Medicaid compensation or knowingly submits false information in order to obtain authorization to provide items or services is guilty of a Class A misdemeanor.
3. **Social Services Law §366-d.** This section is the state-level anti-kickback law, specifically applicable to Medicaid. The law prohibits Medicaid providers from giving or receiving any payment in exchange for the referral of services paid for by Medicaid. Unlike the federal anti-kickback law, §366-d is not an intent-based law, meaning that if the payment is for referrals, the statute is violated regardless of whether the provider intended to obtain referrals. A violation of §366-d is a Class E felony if the provider receives more than $7,500 in Medicaid payments as a result of the illegal referral arrangement.

4. **Penal Law Article 155, Larceny.** The crime of larceny applies to a person who, with intent to deprive another of his property, obtains, takes or withholds the property by means of trick, embezzlement, false pretense, false promise, including a scheme to defraud, or other similar behavior. It has been applied to Medicaid fraud cases.

   a) Fourth degree grand larceny involves property valued over $1,000. It is a Class E felony.
   
   b) Third degree grand larceny involves property valued over $3,000. It is a Class D felony.
   
   c) Second degree grand larceny involves property valued over $50,000. It is a Class C felony.
   
   d) First degree grand larceny involves property valued over $1 million. It is a Class B felony.

5. **Penal Law Article 175, False Written Statements.** Four crimes in this Article relate to filing false information or claims and have been applied in Medicaid fraud prosecutions:

   a. §175.05, Falsifying business records involves entering false information, omitting material information or altering an enterprise’s business records with the intent to defraud. It is a Class A misdemeanor.
   
   b. §175.10, Falsifying business records in the first degree includes the elements of the §175.05 offense and includes the intent to commit another crime or conceal its commission. It is a Class E felony.
   
   c. §175.30, Offering a false instrument for filing in the second degree involves presenting a written instrument (including a claim for payment) to a public office knowing that it contains false information. It is a Class A misdemeanor.
   
   d. §175.35, Offering a false instrument for filing in the first degree includes the elements of the second degree offense and must include an intent to defraud the state or a political subdivision. It is a Class E felony.

6. **Penal Law Article 176, Insurance Fraud,** applies to claims for insurance payment, including Medicaid or other health insurance and contains six crimes.

   a. Insurance Fraud in the fifth degree involves intentionally filing a health insurance claim knowing that it is false. It is a Class A misdemeanor.
b. Insurance fraud in the fourth degree is filing a false insurance claim for over $1,000. It is a Class E felony.

c. Insurance fraud in the third degree is filing a false insurance claim for over $3,000. It is a Class D felony.

d. Insurance fraud in the second degree is filing a false insurance claim for over $50,000. It is a Class C felony.

e. Insurance fraud in the first degree is filing a false insurance claim for over $1 million. It is a Class B felony.

f. Aggravated insurance fraud is committing insurance fraud more than once. It is a Class D felony.

6. **Penal Law Article 177, Health Care Fraud**, applies to claims for health insurance payment, including Medicaid, and contains five crimes:

   a. Health care fraud in the fifth degree is knowingly filing, with intent to defraud, a claim for payment that intentionally has false information or omissions. It is a Class A misdemeanor.

   b. Health care fraud in the fourth degree is filing false claims and annually receiving over $3,000 in aggregate. It is a Class E felony.

   c. Health care fraud in the third degree is filing false claims and annually receiving over $10,000 in the aggregate. It is a Class D felony.

   d. Health care fraud in the second degree is filing false claims and annually receiving over $50,000 in the aggregate. It is a Class C felony.

   e. Health care fraud in the first degree is filing false claims and annually receiving over $1 million in the aggregate. It is a Class B felony.

### Chapter 442 of 2006

*Last year the most sweeping Medicaid fraud package in the history of the state was passed. What are some of the highlights?*

Chapter 442 of 2006 was the most sweeping Medicaid fraud enactment in the history of the program. It contained not one, but many laws to address the issue, from setting up an Inspector General office with prosecutorial and regulatory authority, a mandate that providers implement corporate compliance programs, a battery of new criminal offenses, and a host of laws to improve regulatory oversight. The highlights of the new law are summarized below.

I. **Medicaid Inspector General**

The centerpiece of Chapter 442 was the creation of the Office of Medicaid Inspector General (OMIG) in DOH. Under the law, the Inspector General serves at the pleasure of the Governor...
and reports directly to the Governor. OMIG is given broad authority to coordinate and manage all state activities to combat Medicaid fraud, except those of the Medicaid Fraud Control Unit in the Attorney General’s office.

The powers granted to OMIG include pursuing administrative and civil enforcement actions, imposing sanctions, excluding providers from the Medicaid program, and making civil recoveries. In addition, OMIG is authorized to refer potential criminal cases to the Medicaid Fraud Control Unit as well as other federal or state law enforcement agencies.

In order to carry out its responsibilities, OMIG is authorized to issue subpoenas and compel witnesses to testify under oath, require the production of books, records and other documents as OMIG determines may be relevant, remove records and conduct on-site facility inspections, among other things. The Inspector General has the power to suspend Medicaid payments to providers pending an investigation. In addition, OMIG may take any action authorized by other state or federal laws.

OMIG also has regulatory powers that rival those of any state agency. Public Health Law § 32 empowers OMIG to “implement and amend, as needed, rules and regulations relating to the prevention, detection, investigation and referral of fraud and abuse. . .” OMIG’s regulatory scope is extraordinary: regulations may issue on any matter “relating to” fraud and abuse.

In some respects, OMIG has broader authority than even the Attorney General’s Medicaid Fraud Control Unit (MFCU). While MFCU prosecutes criminal offenses, which OMIG cannot, OMIG has regulatory and surveillance power that MFCU does not.

II. Claims Administration

Chapter 442 directs DOH, in consultation with OMIG, to require the administrator of the Medicaid Management Information System to undertake several responsibilities to improve fraud detection and “improve expenditure accountability.” At a minimum, the administrator or other contractor must implement a prepayment claims review system designed to identify inadvertent or intentional coding errors, misjudgments, incorrect bills and possible excessive billing; to implement a comprehensive coordination of benefits system to assure that Medicaid is the payer of last resort; conduct comprehensive reviews of paid claims and implement targeted claims and utilization reviews.

III. Provider Compliance Programs

New York is the first jurisdiction, state or federal, to mandate corporate compliance programs for Medicaid providers. Chapter 442 added a new §363-d to the Social Services Law to require that certain Medicaid providers implement corporate compliance programs. The law delineates eight characteristics that must be included in a compliance program, tracking the recommendations of the federal Office of the Inspector General. A compliance program must have:
- written policies and procedures that describe compliance expectations and guide the operation of the compliance program;
- designation of a position responsible for day-to-day operation of the compliance program;
- education and training of employees, directors, and officers on compliance program features, expectations, and operation;
- communication lines to the administrator of the compliance program to allow all employees to voice compliance concerns, including the option to do so anonymously and confidentially;
- disciplinary policies that encourage compliant behavior and sanction non-compliant activities;
- systematic identification of compliance risk areas and self-evaluation by use of internal or external audits;
- systematic responses to identified compliance problems and the prompt correction of causes, with the implementation of controls to help prevent recurrence; and
- non-retaliation and non-intimidation policies to protect and encourage good faith participation in the compliance program.

The legislation provides that the compliance program requirement applies to all Public Health Law Article 28 and Article 36 entities and all Mental Hygiene Article 16 and Article 31 facilities and any other service provider that OMIG, in consultation with DOH, identifies for which Medicaid comprises a substantial portion of their business operation.

III. Superintendent’s Reports on Health Insurance Fraud

Chapter 442 added a new Section 410 to the Insurance Law to require the Superintendent of Insurance to issue annual reports summarizing the Insurance Department’s efforts to combat health insurance fraud. The report must describe the number of referrals received, investigations initiated and completed as well as other relevant information.

IV. New Criminal Laws

The fraud package includes the enactment of five new criminal laws, “Health Care Fraud” in the first through fifth degrees. Under the law, a person may be convicted if, “with the intent to defraud a health plan, he or she knowingly and willfully provides materially false information” and receives a payment to which he or she is not entitled. A fifth degree offense consists of fraudulently receiving up to $3,000 from a plan. The remaining crimes have the same substantive standard but vary by the amount in question:

- Fourth degree—the amount received exceeds $3,000 from any one plan in any one year;
Third degree—the amount received exceeds $10,000 from any one plan in any one year;
Second degree—the amount received exceeds $50,000 from any one plan in any one year; and
First degree—the amount received exceeds $1 million from any one plan in any one year.

Note that these crimes apply to any health insurance, including but not limited to Medicaid. Medicaid is considered one single plan for calculating the level of crime. The penalties are steep; a fifth degree offense is a misdemeanor, but a first degree offense is a Class B felony, imposing heavy fines and prison sentences.

**What effect have the 2006 laws had?**

As a general matter, most of the laws contained in Chapter 442 took effect on January 1, 2007. As a result, it is too early to evaluate their impact. OMIG, however, has been very active. It actively investigates cases and makes recoveries.

Interestingly, OMIG has inserted itself into the Certificate of Need process by imposing unique conditions on the approval of projects under review by the Public Health Council, the State Hospital Review and Planning Council, and the Commissioner of Health.

*At the conclusion of the Legislative Session, the then Attorney General criticized the Legislature for abandoning its responsibility, didn’t he?*

Yes. In June, just before the Legislature acted on the legislation, the Attorney General claimed that “the Legislature’s so-called Medicaid fraud reform bill excludes the most important fraud-fighting reforms, and includes new crimes that seem designed to protect those who engage in these criminal activities.

The Legislature should drop the harmful crimes from the bill, and add the Martin Act and FCA provisions. If they do not, it will clearly demonstrate that they are not serious about addressing the problem of Medicaid fraud.”

So while the Legislature and most observers thought the 2006 fraud package was far-reaching, the Attorney General essentially said the Legislature was “not serious” and that the new crimes were actually “harmful.”

**The False Claims Act**

*The debate on the false claims act was intense last year. What’s so controversial?*

There were many reasons for the controversy about the wisdom of a false claims act in New York. Many of them focused on the desirability of enacting a “bounty hunter” law and the need
for any more laws that simply are redundant of laws already enacted. Some of the issues are as follows:

What do false claims laws prohibit?

I. Overview

The FCA, on which the Governor’s budget provision is entirely based, is not limited to health care claims or the Medicaid program. Instead, it addresses any claims for payment from the applicable government entity and any situation in which a company is selling goods, supplies, and services to the government entity.

The portions of the federal FCA and the Governor’s bill relevant to Medicaid specify that it is illegal to: i) knowingly present to the government a “false or fraudulent” claim for payment or approval; ii) knowingly use a false record to get a false or fraudulent claim paid; or iii) conspire to defraud the government to get a false claim paid. Basically, the federal law and state proposals make it illegal to present false or fraudulent claims for payment or to take actions to get false or fraudulent claims paid. They also provide that actions are illegal even if the claimant does not intend to defraud the government.

Are there state laws that make “false claims” illegal now, at least concerning Medicaid?

II. State “False Claims” Laws

Yes. New York’s Social Services Law contains provisions that specifically address false claims and related matters. Section 145, for example, addresses fraudulent attempts to obtain public assistance. Under §145, a person is guilty of a misdemeanor, a crime, for using a “false statement,” deliberate concealment, impersonation, “or other fraudulent device” to obtain public assistance for which the person is not eligible. People who help such individuals engage in these behaviors may also be guilty of a misdemeanor. When a local social services official suspects that these activities are occurring, the matter is referred to the local district attorney for prosecution.

What about provider “False Claims”? 

Provider false claims are extensively addressed in §145-b of the Social Services Law. The law is very broad—it is illegal for a person to attempt to obtain payment by knowingly using a “false statement or representation, or by deliberate concealment of any material fact, or other fraudulent scheme or device, on behalf of himself or others.” The language in §145-b is very similar to the FCA language—the use of a “false statement” or a “fraudulent” scheme or device is a key element of a violation.

The statute identifies what is meant by a “statement”—a claim for payment; an “acknowledgement, certification, claim, ratification, or report of data which serves as the basis
for a claim or rate of payment,” financial information including cost reports, a description of health care services rendered, and the qualifications of persons rendering health services. If any of these or similar documents is false, §145-b applies.

Note that the statute refers to individual claims and other documents specific to payment or a particular service as well as cost reports and other financial documents that relate to rate-setting. Since the law refers to both a “claim” and a “certification,” a single claim that is certified as true and accurate but is not may constitute at least two violations—a false “claim” and a false “certification.” If the underlying medical information is inaccurate, a third violation, regarding the services rendered, may also attach to the same “claim.”

What are the FCA penalties?

III. False Claims Laws’ Penalties

The federal FCA and the Governor’s proposal have severe penalties if violations occur. They provide that the government is entitled to recover three times the amount of damages actually incurred. In addition, the court must assess a penalty of at least $5,000 and no more than $10,000 for each violation. This means that for each claim, i.e., each contested bill, the penalty is $5,000-10,000 no matter how large or small the claim.

The only discretion the court has is to lower the damages to double actual damages, rather than triple them. The court may only do so if the subject entity self-discloses all information it has regarding the claims within 30 days of receiving the information; the entity fully cooperates with the government in the course of the investigation; and the entity did not actually know about any pending civil, criminal, or administrative investigation of the claims when the self-disclosure was made.

What are the current penalties under § 145-b?

Comparing current state law with the federal law and state legislative proposals shows that New York already has a “false claims act.” It is simply titled differently: “False statements; treble damages.” The same actions that constitute violations of the proposed FCA constitute violations of §145-b. Moreover, the consequences are nearly identical—treble damages and per-violation penalties in the thousands of dollars.

The consequences for violating §145-b are severe and very similar to the penalties for violating the proposed FCA. As for damages, the state or a locality may recover three times the amount of actual losses incurred. This is identical to the treble damage provision of the FCA. In addition, the state law has per-claim penalties.

DOH may impose an additional penalty of up to $2,000 for every item or service in violation of §145-b if it finds that a provider has not complied with “the standards of the medical assistance program or of generally accepted medical standards in a substantial number of cases” or grossly and flagrantly violated the standards on a single occasion. These penalties apply if: i) the services in question were unnecessary, improper, or excessive; ii) the care and services were not
provided as claimed; iii) the person ordering the care and services was suspended from participating in the program; or iv) the services were not in fact provided. If the subject person/entity has violated Section 145-b within the prior five years, the per-claim penalty is up to $7,500.

Penalties may be imposed more expeditiously under §145-b than under the Governor’s FCA proposal. Under current state law, DOH may impose the penalty administratively. Under the federal law and state proposals, a court only imposes the penalty after the judicial proceedings have concluded with findings of guilt. Further, with regard to damages, the federal FCA and state proposals allow a court to impose double instead of treble damages. No comparable provision is in §145-b.

If New York enacts a separate FCA, and if the same type of activity could violate both §145-b and a state FCA, could a provider be prosecuted for both? If so, would the treble damages and per-claim penalties of each law apply, effectively doubling the consequences? This would not be an unusual outcome, since often a person or an entity can be found to run afoul of two laws and be subject to the penalties applied in each. Since neither §145-b nor the proposed FCA is a criminal statute, the level of proof in each is minimal—a preponderance of the evidence in the case of an FCA and substantial evidence in the case of §145-b. Proving one essentially would prove the other.

What are “qui tam” laws?

IV. “Qui Tam” Provisions

“Qui tam” is a law that allows private citizens to act as government prosecutors and bring lawsuits as if they were the government. These laws provide that if the lawsuit ends in dollars being recovered by the government, the person originally bringing the case, the “qui tam,” is awarded a percentage of the recovery.

Qui tam cases are kept secret—when a qui tam case is filed in court, it is automatically sealed and its contents are only revealed to the government. The entity subject to the lawsuit has no right to be told the case exists or is filed. The government can decide whether to take over and prosecute the case or to let the qui tam proceed on his or her own and prosecute the case as if the qui tam were the government. Sometimes it can take months, in some cases, more than a year, for the government to decide. Meanwhile the subject provider is kept in the dark. The case is only opened and the provider informed, once the government makes its decision.

When a qui tam case ends, the qui tam gets a reward or bounty. Under federal law, if the government took over the case, the qui tam gets 10%-25% of the proceeds; if the government does not take it over, the qui tam gets 15%-30% of the proceeds. Under the Governor’s bill the qui tam receives 15%-25% if the government takes over the case and 25%-30% of the proceeds if the government does not. The judge overseeing the case decides the final amount.

In fact, under the federal law, which the Governor’s bill copies nearly verbatim, the only factors the judge is to consider are the extent of the qui tam’s cooperation, the value of the information
the qui tam provides, whether the qui tam’s information comes from “insider” sources rather than public sources, and how big the recovery is.

If the *qui tam* did not plan the activity, but nonetheless participated in carrying it out, there is no provision in either federal law or the Governor’s bill for an award reduction. The judge is to rely heavily on the recommendations of the government and may take into account whether “fundamental fairness” demands that the qui tam get a specific percentage reward within the statutory ranges.

*Why is a qui tam provision objectionable?*

A qui tam provision in state law, whether in a new FCA or as an addition to existing law, is objectionable for a number of reasons including conflicts with existing law and protocols, motives, tactics, litigation procedures, and other issues.

A. **The State Whistleblower Law**

New York currently does not have a qui tam law. However, New York does have a longstanding “whistleblower” law that applies to all employees and employers.

Under §§ 740 and 741 of New York’s Labor Law, employees who report violations of law to public officials are protected from employer retribution for doing so; thus, “whistleblowers” who are on the “inside” of a provider’s operations are protected if they report wrongdoing. A qui tam law provides no further protection to the whistleblower—it provides a monetary reward. Its effectiveness can only be measured by employees’ interest in recoveries, not employees’ protection from retaliation or desire to fight fraud.

Section 740 of the Labor Law provides that employers may not take any “retaliatory action” against an employee for providing information to officials, including law enforcement officials, about violations of the law. The law is intentionally very broad and is construed broadly by the courts to provide maximum protection to employees who bring wrongdoing to the attention of authorities. The notion that New York needs a qui tam law because we need “insiders” to come forward is simply spurious. The state’s whistleblower law has been on the books for more than 20 years.

By their nature, qui tam laws amount to privatizing a government prosecutorial function. Laws are generally enforced by government agencies that act on behalf of citizens at large—qui tam cases are brought by private individuals in the name of the government to enrich themselves. The government gives up a portion of its share of recoveries to one individual, hardly benefiting society as a whole.

Under the whistleblower law, the employee provides the information to the official who then acts on the information in his/her official capacity. The qui tam law is wholly inconsistent with the fundamental principle that government, not private citizens, prosecutes violations, especially violations that harm the state, not the individual. The whistleblower law carries out that principle.
A second significant distinction is that under a qui tam law, the private citizen is given a monetary award. Under New York’s Labor Law, the private citizen is shielded from employment retaliation. A qui tam law awards the private person even though that person suffered no harm or injury. The government simply gives up a significant percentage of what is government property, the proceeds of the action, to a private individual. Under the whistleblower law, the wronged employee may sue the employer for his/her injuries and recover from the employer amounts that are determined to be his/her own compensation. The person is further made whole by being reinstated to the former employment position.

**B. Qui Tam Motives**

Rather than a weapon to fight fraud, qui tam laws provide incentives for employees and competitors to act out of retribution. Rather than a tool to fight fraud, qui tam laws merely reward individuals for acting out of any motivation, often retribution or greed.

Qui tam laws reward plaintiffs who have participated in the fraudulent scheme, or who are aware of the scheme and do nothing to stop it, and who may have reaped monetary or other rewards for doing so. The net effect of a qui tam statute is to financially reward wrongdoing or intentional inactivity at the expense of providers and the government.

Some plaintiffs seek the reward because they were excluded from the scheme. In other instances, the participant encourages or allows the continuation of the scheme, knowing that the longer it progresses, the larger the recovery, and the larger the reward.

These and other similar incentives encourage the breakdown of healthy employer-employee relations. A sizeable monetary reward in the offing may provide an incentive for an employee to seek out problems and, rather than try to solve them quickly and efficiently, become intimately familiar with the details (if not an active participant) in order to put a qui tam case together. The dynamic that the qui tam arrangement encourages is counterproductive in that it promotes self-interest rather than problem solving and fails to reward integrity.

**C. Qui Tam Tactics**

Not only is it common for the qui tam plaintiff to have been a participant in the questionable activity, it is also common that the potential qui tam plaintiff resorts to questionable acts to build a case. It is commonplace for qui tam plaintiffs to obtain documents by whatever means they deem necessary to bring and prove a case. Instances of document theft by plaintiffs happen frequently to build cases. Such actions do not diminish the reward due to the plaintiff, nor do they disqualify the plaintiff from receiving any reward.

The federal qui tam law encourages this activity. It does so by providing that the amount of the qui tam’s recovery varies with the extent of cooperation and the value of the documents provided by the qui tam. The more valuable the information, the higher the reward. There is no provision for downgrading the reward because the information was obtained illegally. The quality and
integrity of the qui tam plaintiff’s behavior is simply not taken into account when calculating the reward.

D. Compare With Labor Law § 740

Qui tam laws encourage individuals to act outside of statutory and policy guidelines. As noted above, §740 of the Labor Law protects employees who provide information to law enforcement officials and others. Section 740, however, conditions the protection on a key criterion. In order to be given the protection, an employee must first have “brought the [employer’s] activity, policy or practice in violation of law, rule or regulation to the attention of a supervisor of the employee and has afforded such employer a reasonable opportunity to correct such activity, policy or practice.” It is reasonable that the State Legislature determined that there should be an opportunity to address an issue, resolve it, and maintain compliance before government intervention.

The qui tam portion of the Governor’s bill completely ignores this principle. The eligibility to receive a reward and the size of the reward are not conditioned on any requirement that the person with knowledge take any step to attempt to have the problem solved. In fact, it is often in the prospective qui tam’s interest to see the matter perpetuated, thus increasing the potential award. This setup flies in the face of New York’s well-established statutory requirement that when a problem is spotted, the first response should be to try to solve it.

E. Corporate Compliance Programs

Qui tam provisions undermine effective corporate compliance programs by encouraging employees to put personal reward ahead of rapid, internal correction. The new state law, Social Services Law §353-d and the federal Department of Health and Human Services’ Office of Inspector General (OIG) corporate compliance program protocols require that issues first be reported “up the ranks” to be resolved internally before becoming significant problems. New York is the only state in the country to mandate corporate compliance programs due to the enactment of Chapter 442 in 2006.

Qui tam laws runs contrary to policies as laid out by OIG and as specified in new Social Services Law 363-d. OIG and the state law lay out the seven elements of an effective compliance program. The eight elements were drawn from the Guidelines of the U.S. Sentencing Commission, which have been used by federal judges in sentencing corporate defendants. Since the 1998 publication of the hospital guidance, OIG has published ten other guidances applicable to such health entities as physician offices, durable medical equipment companies, nursing homes, and pharmaceutical manufacturers.

Several elements are of particular note here. The first is that there must be clear and thorough policies and procedures for keeping an organization’s operations in compliance with laws, rules, and regulations. Included in these should be a code of conduct that “should articulate the hospital’s commitment to comply with all federal and state standards, with an emphasis on preventing fraud and abuse. They should state the organization’s mission, goals, and ethical requirements of compliance and reflect a carefully crafted, clear expression of expectations for
everyone associated with the facility. According to OIG and under New York law, these should be distributed to and understood by all employees.

A second element is that the facility should have a high-ranking compliance officer to oversee all compliance activities. The officer should receive communications, either by identified individuals or anonymously, of suspected issues and should be responsible for following up on these reports. The compliance program itself should include self-audits of identified risk areas, again with the goal of detecting issues and preventing their perpetuation. Once an issue is identified, the compliance officer should ensure that appropriate follow-up and remediation is implemented.

The goal of the New York law and OIG’s Compliance Guidance is to maintain vigilance to minimize noncompliant behavior. A qui tam law encourages individuals to operate outside this framework. If an employee identifies an issue and reports it internally, even anonymously to the compliance officer, and the problem is addressed, the opportunity to bring a qui tam case is lost. The best way for an employee to preserve the opportunity for the eventual reward is to not report issues, completely contrary to the spirit and purpose of current New York law and OIG’s recommendations.

F. Litigation Procedure

A qui tam case is prepared without the involvement of government officials and is filed in federal court if brought under the federal act. The provider is not informed and the case is immediately sealed. The papers are then transmitted to the United States Attorney for that area. The defendant is never informed that the case has been filed, that prosecutors have the papers or of the contents of the papers. As a result, there is no opportunity to address the issues presented until they arise in a full-blown fraud lawsuit once the government decides to act.

Government prosecutors are then provided an opportunity to decide whether to take over the case or let the qui tam proceed on his/her own. The process may take several months or over a year. During that time, the qui tam continues to search out information to bolster the case and the defendant is kept in the dark. It is only after the government decides whether to take the case that the papers are unsealed and the defendant is confronted with the case. Extensive discovery and other investigative activity have taken place without the defendant’s knowledge.

Obviously, the defendant organization, unaware of what has been happening, has prepared no papers to present its case. If unaware of the underlying problem, the defendant organization likely has not had the opportunity to use its compliance program as it is intended to be used—to address the problem efficiently and expeditiously. The qui tam procedural apparatus ignores what other government policies strive to promote—rapid identification and remediation of problems.

The opportunity for a private citizen to act as a government prosecutor and be paid a sizeable reward for doing so is a strong incentive to bring a qui tam action. It is well known that a thriving legal specialty has mushroomed: specialists in compiling qui tam lawsuits, with their attendant healthy contingency fees. For defendants, this practice causes the diversion of
substantial dollars to attorneys, consultants, accountants, and others that must be hired to defend such a case. Since the damages and penalties under a false claims act are so severe, a defendant can ill-afford to insist on cost-cutting by its defense team. The result is that dollars intended for patient care go to defending qui tam cases, regardless of their merits.

New York has an extensive legal arsenal to combat fraud. The Attorney General has wide-ranging power to investigate and prosecute fraud. A state FCA would not make illegal something that is now “slipping through the cracks.” However, it would set up counterproductive incentives to hunt for rewards rather than curtail improper payments. Under existing statute and policies, employees are encouraged to report issues and are fully protected if they do. The presence of the bounty, however, turns the activity into a hunt for an award, not a battle against fraud.

*The Governor’s proposal extends beyond federal law in an unusual respect, doesn’t it?*

At the conclusion of the Governor’s false claims legislative section is an unprecedented provision. It proposes to add a new §194 to the State Finance Law to authorize the Attorney General to ‘adopt such rules and regulations as is necessary to effectuate the purposes’ of the state false claims act.

The federal FCA has no such grant of authority to the Attorney General of the United States. Furthermore, there is no precedent in New York law giving the Attorney General the power to adopt regulations.

The Attorney General’s office is the state’s lawyer. The office provides legal services to the state. It is not a policy-making agency, nor has it ever been granted regulatory authority. It is completely contrary to a government of checks and balances to vest the state’s legal office with administrative rulemaking authority.

*The federal Deficit Reduction Act provides a monetary incentive to encourage states’ enactment of false claims laws. Won’t New York lose out on millions, or according to the Attorney General, “billions” of federal dollars for failure to enact a false claims law?*

**V. The Deficit Reduction Act of 2005 and State False Claims Laws**

Section 6031 of the Deficit Reduction Act of 2005 (DRA) provides a monetary incentive to states that enact qualified false claims acts. The incentive is that for any Medicaid recoveries obtained under a case brought pursuant to the state’s law, the federal share is reduced by ten percentage points. In order for a state to retain a higher-than-normal share of the recovery, its law must be reviewed and deemed satisfactory by OIG.

The federal law provides the incentive only when a recovery flows from the filing of a state false claims case. This means that the vast majority of amounts recovered through self-reports, routine adjustments, and audits are not covered by the federal law. Furthermore, the United States Department of Justice has reported that the median elapsed time from commencement of a
false claims case to its resolution, by settlement or otherwise, is 38 months. Thus contrary to some assertions, the state will not be “penalized” for failure to enact a qualified false claims act. The most that can be said is that in the long run, enactment may have a negligible effect on the Medicaid program and in the first few years, it will have virtually no effect.

A second feature of the federal law warrants comment. States are eligible for enhanced recoveries if their laws have been “approved” by OIG. As of February 1, 2007, OIG has reviewed ten state laws, including Texas (TX), California (CA), Florida (FL), and Illinois and only two—Massachusetts and Tennessee—passed OIG’s litmus test, deemed as effective as the federal Act. The “failed” state laws are as follows:

- **Statute of limitations.** Nevada’s false claims act was rejected because it requires an action be filed no more than three years after the date of discovery of the fraudulent act or no more than five years from the date the activity occurred, whichever is earlier. The federal Act provides for a six-year window.

- **Rewarding and facilitating qui tam actions.** The TX act does not allow a relator to bring a civil action on behalf of the United States if the TX Attorney General declines to intervene. The TX law only provides the relator with 10% of the proceeds of the settlement, whereas the federal allows the relator 15%. Further, recovery allowance for damages is not as generous in the TX law.

- **Definitions.** The federal FCA provides definitions of “knowing” and “knowingly” with respect to disregard of truth or falsity of information. The Indiana Act fails to define these two terms, which disqualifies the statute.

- **Government intervention.** The federal FCA allows government to intervene at a later date upon a showing of good cause even if it elected initially not to proceed with an action. Louisiana (LA) did not meet the requirements of DRA, because its false claims act did not provide for government intervention after initial election not to proceed with an action. Also LA qui tam recoveries were not as generous or “effective” in rewarding and facilitating qui tam actions as the federal version.

- **Penalties and treble damages.** The federal Act sets the floor and ceiling for civil penalties, which must be met exactly by a state act. The penalties set by CA, Nevada, and LA failed to meet exactly this requirement. Michigan (MI) allows for treble damages but does not permit the recovery of a penalty for each false claim.

- **Liability.** The MI act does not create a cause or action in the event an individual falsifies a document or attempts to avoid an obligation to pay money to the government, which further disqualifies the state’s act.
“False or fraudulent claims.” The FL act was denied based on the absence of the descriptive “fraudulent” when referring to the “knowingly cause to be presented” false (not “fraudulent”) claim.

Given OIG’s track record thus far, even the most miniscule of reasons can disqualify the state law from the DRA incentive. The DRA hardly compels New York to enact a false claims law. It may not be adequate as a law, and it would not result in any appreciable revenue gain to the state. The DRA is at best a flimsy reason to enact a state FCA.

Federal Fraud Laws and Initiatives

So adding the provisions of Chapter 442 of 2006 to the laws that were already on the books leaves New York with an arsenal of anti-fraud laws. Aren’t there as many, if not more federal anti-fraud laws?

The number of state fraud laws is far eclipsed by those at the federal level. Numerous criminal, civil, and administrative sanctions are federally authorized. Rather than provide an exhaustive description of these laws, brief summaries are as follows:

I. Criminal Laws

- The Federal Criminal False Claims Act (18 U.S.C. § 287) which makes intentionally presenting a false, fictitious or fraudulent claim to any federal agency punishable as a felony;
- Filing False Statements (18 U.S.C. § 1001) which criminalizes the knowing and willful submission of material information, knowing it is false, to any federal agency;
- Mail Fraud and Wire Fraud (18 U.S.C. §§ 1341 and 1343), criminalizing a scheme or artifice to defraud by use of the mail, including electronic mail and wire transfers;
- Medicare and Medicaid Fraud (42 U.S.C § 1320a-7b(a)(1)) making it a felony to knowingly and willfully make a materially false filing, to obtain either benefits or payment;
- The Federal Anti-kickback Law (42 U.S.C. §1320a-7b(b)) criminalizes offering or accepting anything of value to induce the referral of items or services paid for in whole or in part by a federal health care program, including Medicaid;
- Health Care Fraud (18 U.S.C § 1347), created by (Health Insurance Portability and Accountability Act of 1996 (HIPAA), provides for a ten-year prison term for knowingly and willfully executing a scheme to defraud any health care benefit program;
- Disposing of Assets to Obtain Medical Coverage (42 U.S.C. § 1320a-7b(a)(6) criminalizes counseling a person, for a fee, to dispose of assets to
qualify for benefits when the person is otherwise ineligible to receive benefits;

- Federal Program Fraud (18 U.S.C § 666) criminalizes diversion of federal program funds from intended recipients by use of fraudulent devices;
- Theft of Government Property (18 U.S.C. § 641) criminalizes the intentional theft of government property and is often used to federally prosecute common theft;
- Theft or Embezzlement in Connection with Health Care Fraud (18 U.S.C. § 669); and
- False Statements Relating to Health Care Matters (18 U.S.C. §1035) provides for fines and up to five years’ imprisonment for knowingly submitting false or fraudulent information in connection with payment by a federal health care program.

II. Civil and Administrative Laws

- The False Claims Act (31 U.S.C. §§ 3729 - 3733) provides for treble damages and per-violation penalties as well as awards to qui tam plaintiffs for the filing of false or fraudulent claims;
- The “Stark” Law (42 U.S.C § 1395nn) prohibits physicians from making referrals to entities in which they have a financial interest, unless certain exceptions are met; and
- The Program Fraud Civil Remedies Act of 1986 (31 U.S.C. §§ 3801 – 3812) provides for double damages and penalties of $5,000 per claim for submitting any claim the person knows is false or fraudulent, among other things.

The Deficit Reduction Act also included a “Medicaid Integrity Program” provision. What does that say?

III. Federal Medicaid Integrity Program

Section 6034 of the Deficit Reduction Act establishes the “Medicaid Integrity Program” in federal law. It is the first major federal initiative into the Medicaid fraud arena and is designed to place the federal government at the forefront of Medicaid fraud enforcement. Among other things, §6034 requires the publication of Five Year Medicaid Integrity Plans (Plan) and the first Plan was issued by the Centers for Medicaid and Medicare Services (CMS) in July 2006.

Among other things, the Plan states that the Integrity Program will act as a “bully pulpit” to the states to encourage vigorous investigation and prosecution of Medicaid fraud. Working with OIG, the Federal Bureau of Investigation, the Justice Department, and other federal agencies, CMS will oversee state’s efforts and evaluate states’ effectiveness in obtaining recoveries. CMS’ role, however, extends beyond mere oversight. The Plan delineates an aggressive agenda
of audits and recoveries, including suspension of Medicaid payments to providers as CMS deems appropriate.

The Plan indicates that a new cadre of federal agents will be deployed in specified areas of the country, including New York. The agents will support and expand upon the efforts of the State Medicaid Inspector General, the Attorney General’s Office, DOH, and local law enforcement agencies.

*With all of these laws, are there cases that the state is unable to bring because of loopholes that need to be filled? Is that what the FCA and Martin proposals do?*

Not at all. We already have the FCA and whistleblower laws in New York. We do not have a bounty-hunter law.

As to the Martin Act, this is not the 1920s, when legal protections were non-existent. The provisions of the Martin Act are sobering and hardly match the punishment with the crime—especially when considering all the new laws from 2006 that are only now taking effect, let alone the sweeping power the Attorney General already possess under the Executive Law.

Enactment of the proposals advanced by the Governor would be a public concession that what has been enacted and initiated is somehow legally deficient. That is hardly the case. New York does have potent and substantial legal tools for combating fraud. For program administrators, investigators, and prosecutors to call them inadequate brings to mind an old truism—“A poor carpenter blames his tools.”