Western Connecticut Health Network

September 28, 2018

An Important Communication from the WCHN Corporate Compliance Office

THE DEFICIT REDUCTION ACT OF 2005

Pursuant to the *False Claims Recovery Employee Education* provisions in the Deficit Reduction Act of 2005 ("DRA"), Western Connecticut Health Network ("WCHN" or the "Network") is required to inform all of its workforce members, business affiliates, and agents (collectively "Covered Individuals") about:

- WCHN's internal policies covering the prevention and detection of fraud, waste, and abuse;
- The Federal False Claims Act;
- The Federal administrative remedies for false claims and statements;
- Laws of the State of Connecticut ("State") pertaining to civil or criminal penalties for false claims and statements; and
- Whistleblower protections under Federal and State laws.

As a Covered Individual, it is crucial that you are aware of and have reviewed these internal policies and laws to ensure that you carry out your WCHN responsibilities, duties, and role in a manner that is both legally compliant and in adherence with the professional and ethical standards outlined in WCHN's Corporate Compliance and Ethics Program (the "Program").

In accordance with the requirements set forth in the DRA, as well as the mandate of the Program to detect, deter, and prevent fraud, waste and abuse and promote the highest standards of ethical conduct, WCHN's Corporate Compliance Office has prepared, in memorandum form, a summary of these laws and relevant WCHN policies. This memorandum is available to Covered Individuals on the Network's intranet page at: http://thepulse.wchn.priv/Departments/compliance/Pages/Deficit-Reduction-Act-(DRA).aspx and external webpage at: https://www.westernconnecticuthealthnetwork.org/corporate-compliance-and-ethics-program. WCHN is providing this information on its own behalf and on behalf of its affiliates Danbury Hospital (which includes its New Milford Hospital campus), Norwalk Hospital, Western Connecticut Medical Group, Western Connecticut Home Care, and Western Connecticut Health Network Affiliates.

Lastly, it is important to underscore that Covered Individuals may contact WCHN's Confidential Compliance and Ethics Helpline (the "Helpline") at **1-844-395-9331** to report any compliance issues, concerns or incidents that they may be aware of. Reports may also be made confidentially online at: www.wchn.ethicspoint.com. Remember, ***Ask Questions. Voice Your Concerns. Report Improper Conduct***. Note that, Covered Individuals may submit a compliance report through the Helpline anonymously. Further, WCHN strictly enforces its non-retaliation policies and takes every effort to protect whistleblowers from retribution and other retaliatory acts. Covered Individuals are reminded that they may also use the Helpline to seek guidance or ask questions regarding the DRA or other compliance topics.

Thank you for your valued contribution in assisting WCHN in satisfying its obligations under the DRA and meeting its compliance goals and initiatives. We encourage you to view the numerous Program-related policies in their full length on the Network's intranet and external webpage at the links provided above. Your continued and ongoing support of the Program is greatly appreciated.

Wayne A. McNulty
Senior Vice President &
Chief Compliance, Audit & Privacy Officer

Western Connecticut Health Network
Danbury Hospital · New Milford Hospital · Norwalk Hospital

Wayne A. McNulty, Esq., CIPP, CHC
Senior Vice President &
Chief Compliance, Audit & Privacy Officer

MEMORANDUM

To: All WCHN Workforce Members
All WCHN Business Affiliates
All WCHN Agents

From: Wayne A. McNulty
Senior Vice President &
Chief Compliance, Audit & Privacy Officer

Date: September 28, 2018

Re: **Deficit Reduction Act of 2005**

The purpose of this communication is to provide all Western Connecticut Health Network ("WCHN" or the "Network")[1] workforce members, business affiliates, and agents (collectively, "Covered Individuals")[2] with a summary of the employee education provisions concerning fraud, waste and abuse found in the Deficit Reduction Act of 2005 ("DRA"). As a Covered Individual, your understanding of the DRA employee education provisions will assist you in fulfilling your WCHN responsibilities, duties, and role in an ethical and legally compliant manner and in accordance with WCHN's internal standards of conduct.

Accordingly, the passages that follow, along with the accompanying attachment, provide a synopsis of: (i) pertinent provisions of the DRA; (ii) WCHN's policies and procedures that address fraud, waste, and abuse; and (iii) the various United States Federal ("Federal") and State of Connecticut ("State") laws that prohibit the submission of false and fraudulent claims and retaliatory conduct against whistleblowers.

I. OVERVIEW

The DRA was enacted by Congress in early 2006 with a main purpose of eliminating fraud, waste and abuse in the Federal Medical Assistance Program ("Medicaid"). Under the *False Claims Recovery Employee Education* provisions of the DRA, WCHN is required, as a

[1] Consisting of all WCHN-affiliated entities, including Danbury Hospital (which includes its New Milford Hospital campus), Norwalk Hospital, Western Connecticut Medical Group, Western Connecticut Home Care, and Western Connecticut Health Network Affiliates.

[2] For purposes of this memorandum, the term Covered Individuals shall mean all WCHN: (i) workforce members (*e.g.*, employees, affiliates, personnel, medical staff members, governing body members, trainees, volunteers, appointees, and individuals whose conduct is under the direct control of the Network, whether or not they are paid by the Network); (ii) business affiliates (*e.g.*, all non-workforce member contractors, subcontractors, vendors or other third parties who, in acting on behalf of the Network: (a) deliver, furnish, prescribe, direct, order, authorize or otherwise provide Federal healthcare program items and services; (b) perform billing or coding functions; or (c) involved in the monitoring of healthcare provided by the Network); and (iii) agents (*e.g.*, individuals or entities who have entered into an agency relationship with WCHN). *See* CMS DRA 602 – Employee Education About False Claims Recovery – Frequently asked Questions, p.6 (3/20/07), available at: https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/smd032207att1.pdf (last accessed on 9/26/18).

condition of its participation in Medicaid, to establish written policies and procedures that inform Covered Individuals about the following:

- WCHN's internal policies covering the prevention and detection of fraud, waste, and abuse;
- The Federal False Claims Act;
- Federal administrative remedies for false claims and statements;
- Any State law pertaining to civil or criminal penalties for false claims and statements; and
- Whistleblower protections under Federal and State laws.

Pertinent WCHN policies and procedures designed to detect and prevent fraud, waste and abuse are summarized in § II below. Additionally, a detailed outline of: (i) the Federal and State False Claims Acts and whistleblower protection laws; (ii) Federal administrative remedies for false claims and statements; and (iii) State laws governing the imposition of civil and criminal penalties for false claims and statements, may be found annexed hereto in **Appendix A**.

II. WCHN'S POLICIES AND PROCEDURES DESIGNED TO DETECT AND PREVENT FRAUD, WASTE AND ABUSE

WCHN has promulgated numerous policies, procedures, practices, and other initiatives designed to detect and prevent fraud, waste and abuse. Paragraphs A-G set forth below provide an outline of WCHN's key policies that cover this topic. Note that copies of each of the pertinent policies, as well as other compliance-related policies, are available on WCHN's intranet page at: http://thepulse.wchn.priv/Departments/compliance/Pages/Deficit-Reduction-Act-(DRA).aspx, as well as WCHN's external website at: https://www.westernconnecticuthealthnetwork.org/corporate-compliance-and-ethics-program.

A. WCHN Code of Conduct & Business Ethics

Consistent with the guidance issued by the U.S. Department of Health and Human Services Office of Inspector General ("OIG") concerning compliance programs for hospitals and other healthcare entities (*e.g.*, home health agencies and physician groups)[3] that have been adopted by the Network, WCHN's Code of Conduct and Business Ethics ("Code of Conduct" or the "Code") serves as WCHN's constitution with respect to ethical conduct. In broad terms, the Code embodies the heart of WCHN's ethical framework. Among other things, the Code stresses WCHN's commitment to lawful and ethical behavior and high standards of business conduct and integrity. Further, the Code addresses WCHN's expectation of ethical conduct as it relates to areas of risk within WCHN's clinical, administrative, and business operations.

[3] WCHN has adopted the principles set forth in: (i) the 1998 and 2005 U.S. Department of Health and Human Services Office of Inspector General ("OIG") *Compliance Program Guidance to Hospitals* and *Supplemental Compliance Program Guidance to Hospitals*, respectively; (ii) the 2000 OIG *Compliance Program for Individual and Small Group Physician;* (iii) the 1998 OIG *Compliance Program Guidance for Home Health Agencies*; and (iv) the 2016 United States Sentencing Commission Guidelines Manual, § 8B2.1 - *Effective Compliance and Ethics Program.*

Additionally, the Code stresses, in sum and substance, the importance of Covered Individual compliance with "the letter, as well as the spirit" of all applicable laws when carrying out their WCHN activities, functions and duties. Further, the Code highlights the importance of honest, fair, and trustworthy conduct and the avoidance of even the appearance of any conflict of interest between work and personal affairs.

In addition to the foregoing, under the Code, Covered Individuals are expected to adhere to WCHN's ethical standards, including, without limitation, the following:

- Compliance with legal requirements;
- Respect for fellow employees;
- Maintenance of accurate records and documents;
- Avoidance of conflicts of interest;
- Reporting concerns; and
- Discipline for violations.

Finally, the Code of Conduct sets out that WCHN will take disciplinary action, including dismissal when appropriate, against any employee who: (i) violates any legal requirements or institutional policies; (ii) fails to report such violations; or (iii) retaliates against any individual for reporting in good faith a possible violation.[4]

B. Corporate Compliance Program

WCHN's *Corporate Compliance Program* policy describes the key components of its Corporate Compliance and Ethics Program (the "Program"). As stated in this Policy, the Program is intended to ensure full compliance with all applicable Federal and State laws, rules, and regulations and the highest standards of ethical conduct. The operation of the Program emphasizes compliance with all Federal healthcare program (*e.g.*, Medicare and Medicaid) and other third party payor requirements. Key highlights of the Program include:

- Mandatory billing principles such as adherence to all special billing requirements for government-sponsored programs, managed care organizations, and other payors;
- The requirement that all claims be supported by clear documentation in the medical record;

[4] Note that WCHN also has the *Disciplinary Policy*, which ensures that WCHN administers equitable and consistent discipline for the resolution of inappropriate conduct and behavior that aligns with the violation, behavior and/or history of the employee. Namely, pursuant to the *Disciplinary Policy*, the response to the employee may include counseling (verbally or in writing), verbal warning, written warning, performance improvement plan, suspension, and/or any other response deemed appropriate, up to and including, immediate termination of employment.

- The WCHN Corporate Compliance and Ethics Helpline – **its current toll-free number is 1-844-395-9331**; and

- The responsibility of each WCHN clinical department under the Program to monitor departmental billing practices and address corresponding compliance issues as they arise.

C. Adoption of Recognized Compliance and Ethics Program Principles

In addition to the compliance values and requirements mentioned above in the *Corporate Compliance Program* policy (*see* paragraph "B" of this section, *supra*), WCHN has, consistent with OIG and the United States Sentencing Commission Guidelines for effective compliance programs, adopted the following eight (8) key principles as the foundation of the Program:

- ***ELEMENT # 1*** – The development and dissemination of written policies and procedures including, without limitation, standards of conduct (*e.g.*, code of ethics, code of conduct), that promote WCHN's commitment to carrying out its operations in a legally compliant and ethical manner;[5]

- ***ELEMENT # 2*** - The designation of a Chief Compliance Officer ("CCO") to operate and monitor the Program. Additionally, the establishment of a compliance committee for the purpose of, among other things, to provide advice and counsel to the CCO and to assist in the implementation of the Program.[6]

- ***ELEMENT # 3*** **–** The development of training and education for all affected Covered Individuals;[7]

- ***ELEMENT # 4*** **–** The establishment of open lines of communication between the CCO and all Covered Individuals. Additionally, the maintenance of a process, such as a confidential compliance helpline, to receive compliance complaints in an anonymous and confidential manner.[8]

- ***ELEMENT # 5*** **–** The enforcement of disciplinary standards for Covered Individuals who have failed to comply with applicable law, Federal healthcare program requirements, and WCHN's own standards of conduct.[9]

- ***ELEMENT # 6*** **-** The performance of auditing and monitoring to facilitate the ongoing monitoring of the Program.[10]

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[5] *See* U.S. Department of Health and Human Services Office of Inspector General ("OIG"), *Publication of OIG Compliance Program Guidance for Hospitals*, 63 Fed. Reg. 8987, 8989-90, § II & II [A] (1998); *see also* OIG, *OIG Supplemental Compliance Program Guidance for Hospitals*, 70 Fed. Reg. § 4858, 4874, [III][A] (2005) OIG, *OIG Compliance Program Guidance for Individual and Small Group Physician Practices*, 65 Fed. Reg. § 59434, 59436, [II][A] & 59438-59441, [II][B]["*Step 2"*](2000).

[6] *See* 63 Fed. Reg. 8987, 8989 § II & 8993-4 § II [B][1-2]; *see also* 70 Fed. Reg. 4858, 4874, § [III][B][1]; 65 Fed. Reg. § 59434, 59436, [II][A] & 59441-59442, [II][B]["*Step 3*"]; U.S. Sentencing Commission Guidelines Manual, Effective Compliance and Ethics Program, § 8B2.1 [b][1] and Commentary at 1.

[7] *See* 63 Fed. Reg. 8987, 8989 § II & 8994 § II [C]; 65 Fed. Reg. § 59434, 59436, [II][A] & 59442-59443, [II][B]["*Step 4*"].

[8] *See* 63 Fed. Reg. 8987, 8989 § II & 8995 § II [D][1-2]; 65 Fed. Reg. § 59434, 59436, [II][A] & 59443-59444, [II][B]["*Step 6*"].

[9] *See* 63 Fed. Reg. 8987, 8989 § II & 8995 § II [E][1-2]; 65 Fed. Reg. § 59434, 59436, [II][A] & 59444 [II][B]["*Step 7*"].

- ***ELEMENT # 7 –*** The investigation of potential offenses, the development of corrective action plans in response to confirmed violations of the Program and/or applicable law, as well as the mandatory reporting and refunding of any overpayments.[11]

- ***ELEMENT # 8*** – The establishment of anti-retaliation policies.[12]

D. Compliance – Prevention of Fraud, Waste and Abuse

The *Compliance – Prevention of Fraud, Waste and Abuse* policy provides a brief outline of the Federal False Claims Act and mandates all employees, contractors, and agents of WCHN to report fraud, waste and abuse to the Corporate Compliance Office. In addition to providing details regarding the Federal False Claims Act, this policy also provides an overview of the: (i) Federal Program Fraud Civil Remedies Act (also referred to as Provision of Administrative Remedies for False Claims and Statements"), and (ii) Connecticut False Claims Act. Note that, all of these laws are described in greater detail in Appendix A annexed to this memorandum.

E. Non-Retaliation For Reports

WCHN has established a *Non-Retaliation for Reports* policy, which encourages Covered Individuals to report potential non-compliance and prohibits retribution of any kind in response to a Covered Individual's reporting of compliance concerns.

F. The WCHN Compliance and Ethics Helpline[13]

To facilitate open communication of compliance-related questions, issues or concerns, WCHN has established the following toll-free Confidential and Anonymous Compliance and Ethics Helpline (the "Helpline") that is available to all Covered Individuals: **1-844-395-9331.** Reports may also be made confidentially online at: www.wchn.ethicspoint.com. The Helpline has been publicized through the development of an official Helpline poster, which has been posted throughout WCHN's facilities. Copies of the poster were also disseminated on May 21, 2018 to all WCHN workforce members.

As communicated in the Helpline poster, WCHN encourages and expects all Covered Individuals to promptly report any activity or other form of conduct that is contrary to or otherwise interferes with their responsibility to fulfill their day-to-day WCHN work functions, duties, and role in an ethical and legally compliant manner. The Helpline poster calls on all Covered Individuals to do the following to help eliminate prohibited conduct: ***Ask Questions. Voice Your Concerns. Report Improper Conduct.*** To that end, the Helpline poster listed examples of prohibited conduct that warranted reporting including activities that:

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[10] *See* 63 Fed. Reg. 8987, 8989 § II & 8996 § II [F][1-2]; 65 Fed. Reg. § 59434, 59436, [II][A] & 59437-59438, [II][B]["*Step 1*"].
[11] *See* 63 Fed. Reg. 8987, 8989 § II & 8997-8 § II [G][1-2]; 65 Fed. Reg. § 59434, 59436, [II][A] & 59443 [II][B]["*Step 5*"].
[12] *See* 63 Fed. Reg. 8987, 8989 § II & 8995 § II [E][1] 65 Fed. Reg. § 59434, 59436, [II][A] & 59444 [II][B]["*Step 7*"].
[13] In addition to the Helpline, in its *Compliance Reporting of Compliance Questions or Concerns and Organizational Response* policy, WHCN requires that all Covered Individuals report instances of suspected non-compliance (*i.e.*, failure to follow applicable Federal, State or municipal law) or pose questions when a regulation or policy is unclear.

- Constitute fraud, waste, and abuse;
- Violate patient rights;
- Involve the provision of substandard patient care;
- Harm the environment; or
- Create an uncivil and/or unsafe workplace.

G. Compliance – Internal Investigation Policy

The Compliance – Internal Investigation policy was enacted to create a consistent and efficient procedure for responding to incidents of non-compliance and other violations of the Program that are brought to the attention of the Corporate Compliance Office through monitoring and reporting mechanisms. The subject policy calls for the CCO, assisted by designated individuals as appropriate, to investigate potential Program violations and oversee corrective actions. Some key responsibilities under the policy include:

- The repayment of overpayments discovered during the conduct of an internal investigation; and
- The notification of the appropriate law enforcement agency where criminal conduct is uncovered during the conduct of an internal investigation.

III. CLOSING

WCHN remains committed to fostering a culture of compliance and ethical behavior. Through the implementation of its Program and the ongoing efforts of Covered Individuals to carry out their functions, duties, and role in a legally compliant and ethically conscious manner, WCHN will continue to be first in class with regard to maintaining high standards of conduct.

Thank you for taking the time to read this important message.

Attachment

cc:
John M. Murphy, M.D., President & Chief Executive Officer

Appendix “A”

Western Connecticut Health Network

Danbury Hospital · New Milford Hospital · Norwalk Hospital

WESTERN CONNECTICUT HEALTH NETWORK

CORPORATE COMPLIANCE OFFICE

DEFICIT REDUCTION ACT OF 2005 -
EMPLOYEE EDUCATION REGARDING FALSE CLAIMS RECOVERY UNDER 42 U.S.C. 1396a (a)(68)[1]

Federal and State Laws related to the filing False Claims;
Administrative Remedies for False Claims and Statements; and
Federal and State Whistleblower Protection Laws

September 28, 2018

[1] The information provided in this Appendix, as well as any links contained herein, are intended solely for informational purposes and guidance, do not represent an all-inclusive list of relevant laws on this topic, and may not reflect recent changes to law. Further, such information shall not: (i) be construed as a substitute for legal counsel; (ii) constitute legal advice; and (iii) create any third party rights. Recipients of this Appendix and underlying memorandum should contact the WCHN Corporate Compliance Office for any questions regarding the content contained herein.

Western Connecticut Health Network

Table of Contents

I. FEDERAL LAWS

A. Federal False Claims Obligation (42 U.S.C. § 1396a (a)(68))

Overview

Deficit Reduction Act of 2005 History and Purpose

As general background, the Deficit Reduction Act of 2005 ("DRA") was enacted into law on February 8, 2006.[2] The DRA contains several provisions reforming Medicare and Medicaid with the intent to reduce program spending and "bolster Medicaid fraud and abuse enforcement."[3] Namely, the law creates a federal Medicaid Integrity program[4] and provides funding for "combatting fraud and abuse in the Medicaid program."[5] Most pertinent to health care providers, the DRA requires providers to enforce potential Medicaid fraud, waste and abuse by adopting and implementing policies and educating employees.[6]

Federal False Claims Obligation Provisions of the DRA

Statutory Provision

The statutory provisions of the DRA provide the following under 42 U.S.C. § 1396a (a)(68):

A State plan for medical assistance must - -

(68) provide that any entity that receives or makes annual payments under the State plan of at least $5,000,000, as a condition of receiving such payments, shall--

(A) establish written policies for all employees of the entity (including management), and of any contractor or agent of the entity, that provide detailed information about the False Claims Act established under section 3729 through 3733 of Title 31, administrative remedies for false claims and statements established under chapter 38 of Title 31, any State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs (as defined in section 1320a-7b[f] of this title);

(B) include as part of such written policies, detailed provisions regarding the

[2] *Deficit Reduction Act of 2005*, Pub. Laws 109–171, 120 Stat. 4 (February 8, 2006), codified at 42 U.S.C. § 1396a (a)(68).
[3] Health Care Compliance Association ("HCCA") Healthcare Professionals Manual, 23,303 ¶ 20,364.
[4] U.S. Department of Health and Human Services, Center for Medicare and Medicaid Services ("CMS"), Medicaid Integrity Program, *General Information* (hereinafter "CMS DRA General Information"), available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/MedicaidIntegrityProgram/index.html (last accessed on September 19, 2018).
[5] Health Care Compliance Association ("HCCA") Healthcare Professionals Manual, 23,303 ¶ 20,364.
[6] *See* Health Care Compliance Association ("HCCA") Healthcare Professionals Manual, 23,320 ¶ 20,378.

entity's policies and procedures for detecting and preventing fraud, waste, and abuse; and

(C) include in any employee handbook for the entity, a specific discussion of the laws described in subparagraph (A), the rights of employees to be protected as whistleblowers, and the entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

B. Federal False Claims Act (31 U.S.C. §§ 3729-3733)[7]

Overview

False Claims Act History

The Federal False Claims Act ("FCA" or the "Act") is a civil law that "protects the [Federal] Government from being overcharged or sold shoddy goods or services."[8] Congress enacted the FCA in 1863 due to its concern that the Union Army was being defrauded by suppliers of goods.[9] In the context of payment for the delivery of healthcare, the FCA prohibits the knowing submission of claims for payment to any Federal healthcare program (*e.g.*, Medicare, Medicaid, or Tricare) that are false or fraudulent.[10]

Penalties for FCA Violations

Generally, the FCA imposes liability on any person who submits a claim to the federal government, or submits a claim to entities administering government funds that he or she knows (or should know) is false. The FCA imposes liability when a person acts "knowingly." Note, however, no specific intent to defraud is required under the FCA.[11] More specifically, the FCA does not require that the person submitting the claim have actual knowledge that the claim is false. Namely, a person can also be found liable under the Act if he or she acts in reckless disregard or in deliberate ignorance of the truth or falsity of the information.[12]

"Filing false claims may result in fines up to three times the [loss to the affected Medicaid and Medicare program] plus"[13] not less than $11,181 and not greater than

[7] A substantial portion of the summary regarding the False Claims Act is based off of the Centers for Medicare and Medicaid Services ("CMS"), CMS False Claims Act Description, publication dated March 8, 2007 *available at* https://downloads.cms.gov/cmsgov/archived-downloads/smdl/downloads/smd032207att2.pdf (last accessed on September 18, 2018)(hereinafter "CMS FCA description").
[8] U.S. Department of Health and Human Services, Office of Inspector General ("OIG"), A Roadmap for New Physicians, *Fraud & Abuse Laws, False Claims Act* [31 U.S.C. 3729-3733] (hereinafter "OIG Roadmap for New Physicians), available at: https://oig.hhs.gov/compliance/physician-education/01laws.asp (last accessed on September 18, 2018).
[9] *See* Department of Justice – False Claims Act Primer, available at https://www.justice.gov/sites/default/files/civil/legacy/2011/04/22/C-FRAUDS_FCA_Primer.pdf
[10] *See id.*
[11] *See* OIG Roadmap for New Physicians.
[12] CMS FCA description *citing* 31 U.S.C. § 3729 [b].
[13] OIG Roadmap for New Physicians.

$22,363 per claim filed.[14] And under the FCA, "each instance of an item or service billed to Medicare or Medicaid counts as a claim…."[15]

Note, also, that the OIG has the authority to seek civil monetary penalties, assessments and exclusion against individuals or entities that present false claims that "the individual or entity knows or should know are for an item or service that was not provided as claimed or is false or fraudulent."[16]

Examples of Potential False Claims Violations

The following are three examples provided by CMS of potential FCA violations.[17] The first is where a physician submits a bill to Medicare for medical services when she knows she has not provided such services. The second is where an individual knowingly submits a false record in order to obtain payment from the government. An example of this may include a government contractor who submits records that he knows (or should know) are false, e.g. indicating compliance with certain contractual or regulatory requirements when the company has failed to do so. The third area of liability includes those instances in which a person obtains money from the federal government that the person is not entitled to, and subsequently uses false statements or records in order to retain the money. "An example of this so called 'reverse false claim' may include a hospital which obtains interim payments from Medicare or Medicaid throughout the year, and then knowingly files a false cost report at the end of the year in order to avoid making a refund to the Medicare or Medicaid program."[18]

Qui Tam Provisions

The FCA provides a procedural avenue for private parties to bring an action on behalf of the United States as a "*qui tam* relator."[19] If successful, a *qui tam* relator may share in a percentage of the proceeds from an FCA action or settlement.[20]

The FCA generally provides that, when the Government has intervened in the lawsuit, a *qui tam* relator shall receive a minimum of 15 percent and a maximum of 25 percent of the proceeds of the FCA action depending upon the extent to which the relator

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[14] *See* Department of Justice, *Civil Monetary Penalties Inflation Adjustment*, 83 Fed. Reg. 3944, 3946 § "Part 85-Civil Monetary Penalties Inflation Adjustment" table under the *Civil Division*, available at: https://www.gpo.gov/fdsys/pkg/FR-2018-01-29/pdf/2018-01464.pdf (last accessed on September 25, 2018). Also note that under the Program Fraud Civil Remedies Act, a person may be liable up to $11,181 per claim and $11,181 per statement. *See id*.

[15] *Id*.

[16] *See* OIG, Background on the Civil Monetary Penalties and Affirmative Exclusions, *Background* (hereinafter "OIG CMP Background"), available at: https://oig.hhs.gov/fraud/enforcement/cmp/background.asp (last accessed on September 19, 2018). *See also* 42 U.S.C. § 1320a-7a [a][1][A-B], which states in relevant part, "[a]n entity that knowingly presents or causes to be presented to Medicare and Medicaid a claim that…is for a medical or other item or service that the person knows or should know was not provided as claimed, including…causing to be presented a claim for an item or service that result[s] in a greater payment to the person than the code [that] is applicable to the item or service actually provided, [or]…is for a medical or other item or service and the person knows or should know the claim is false or fraudulent. *Id.*

[17] CMS FCA description at p. 1.

[18] *Id.* at p. 1.

[19] 31 U.S.C. § 3730 [b].

[20] *Id.*

substantially contributed to the prosecution of the action.[21] When the Government does not intervene, the FCA provides that the relator shall receive a reasonable amount as decided by the court that must be greater than 25 percent and less than 30 percent.[22]

Pertinent Statutory Provisions

The statutory provisions of the False Claims Act ("FCA") provide, in pertinent part, the following under 31 U.S.C. § 3729:

(a) Liability for certain acts.--

(1) In general.--Subject to paragraph (2), any person who—

(A) knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval

(B) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim;

(C) conspires to commit a violation of subparagraph (A), (B), (D), (E), (F), or (G);

(D) has possession, custody, or control of property or money used, or to be used, by the Government 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 and, intending to defraud the Government, 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, or a member of the Armed Forces, 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, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government, is liable to the United States Government for a civil penalty of not less than [$11,181 and not more than $22,363],[23] as adjusted by the Federal

[21] 31 U.S.C. § 3730 [d][1].
[22] 31 U.S.C. § 3730 [d][2].
[23] *See* 83 Fed. Reg. 3944, 3945 § "Part 85-Civil Monetary Penalties Inflation Adjustment" table under the *Civil Division*.

Civil Penalties Inflation Adjustment Act of 1990 (28 U.S.C. 2461 note; Public Law 104-410), plus 3 times the amount of damages which the Government sustains because of the act of that person.

(2) **Reduced damages.**--If the court finds that—

(A) the person committing the violation of this subsection furnished officials of the United States responsible for investigating false claims violations with all information known to such person about the violation within 30 days after the date on which the defendant first obtained the information;

(B) such person fully cooperated with any Government investigation of such violation; and

(C) at the time such person furnished the United States with the information about the violation, no criminal prosecution, civil action, or administrative action had commenced under this title with respect to such violation, and the person did not have actual knowledge of the existence of an investigation into such violation, the court may assess not less than 2 times the amount of damages which the Government sustains because of the act of that person.

(3) **Costs of civil actions.**--A person violating this subsection shall also be liable to the United States Government for the costs of a civil action brought to recover any such penalty or damages…

(b) **Definitions.**--For purposes of this section--

(1) the terms "knowing" and "knowingly" –

(A) mean that a person, with respect to information—

(i) has actual knowledge of the information;

(ii) acts in deliberate ignorance of the truth or falsity of the information; or

(iii) acts in reckless disregard of the truth or falsity of the information; and

(B) require no proof of specific intent to defraud;

(2) the term "claim"—

(A) means any request or demand, whether under a contract or otherwise, for money or property and whether or not the United States has title to the money or property, that—

(i) is presented to an officer, employee, or agent of the United States; or

(ii) is made to a contractor, grantee, or other recipient, if the money or property is to be spent or used on the Government's behalf or to advance a Government program or interest, and if the United States Government—

(I) provides or has provided any portion of the money or property requested or demanded; or

(II) will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded; and

(B) does not include requests or demands for money or property that the Government has paid to an individual as compensation for Federal employment or as an income subsidy with no restrictions on that individual's use of the money or property;

(3) the term "obligation" means an established duty, whether or not fixed, arising from an express or implied contractual, grantor-grantee, or licensor-licensee relationship, from a fee-based or similar relationship, from statute or regulation, or from the retention of any overpayment; and

(4) the term "material" means having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property…

C. Provision of Administrative Remedies for False Claims and Statements (Federal Program Fraud Civil Remedies Act) (31 U.S.C. §§ 3801-3812)

This statute provides the mechanism for administrative recoveries by federal agencies for false claims. Namely, if a person submits a claim that the person knows is false or contains false information, the agency receiving the claim may impose a penalty of up to $11,181[24] for each claim. Additionally, the agency may recover twice the amount of the claim.[25] The determination of whether a claim is false, and the imposition of fines and penalties is made by the administrative agency.[26]

[24] *See* 83 Fed. Reg. 3944, 3946 § "Part 85-Civil Monetary Penalties Inflation Adjustment" table under the *Civil Division*.
[25] 31 U.S.C. § 3802 [a][1][D].
[26] 31 U.S.C. § 3803[a][1].

D. False, fictitious or fraudulent claims (18 U.S.C. § 287)

A person that makes or presents to any United States department or agency any claim "upon or against the United States, or any department or agency thereof, knowing such claim to be false, fictitious, or fraudulent, shall be imprisoned not more than five years and shall be subject to a fine…"[27]

E. Conspiracy to defraud the Government with respect to claims (18 U.S.C. § 286)

A person who enters into any agreement, combination, or conspiracy to defraud the United States, including any U.S. department or agency, by "obtaining or aiding to obtain payment of any false, fictitious or fraudulent claim, is in violation of this section." [28] Such person shall be fined, or imprisoned a maximum of ten years, or both.[29]

F. Other federal health care laws related to the submission of false claims.[30]

Although not specifically required to be communicated under the DRA, the foregoing listing and description of statutes are important for workforce members, business affiliates, and agents to know in order to assist WCHN in its efforts in maintaining an effective compliance and ethics program, to understand their obligations under WCHN's Code of Conduct, and to comply with all applicable Federal and State laws. Violation of any of the provisions, as described in further detail below, may result in imprisonment and forfeiture of assets and property, as applicable.[31]

1) Anti-Kickback Statute (42 U.S.C. § 1320a-7b [b]).[32]

Generally, the Anti-kickback statute ("AKS") is a criminal law that prohibits the knowing and willful payment or receipt of "remuneration" to induce or reward patient referrals[33] or the generation of business involving any item or service payable by the Federal health care programs.[34] Examples of items or services include drugs, supplies, or health care services for Medicare, Medicaid, or Tricare patients. The definition of "remuneration" is broad and includes anything of value and can take many forms besides cash. For example, remuneration can include free or reduced rent, expensive hotel stays and meals, and excessive compensation for medical directorships or consultancies.[35]

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[27] 18 U.S.C. § 287.
[28] 18 U.S.C. § 286.
[29] 18 U.S.C. § 286.
[30] Note that 18 U.S.C. § 24 delineates the violations that are deemed "Federal health care offenses." Such violations are described in more detail in the foregoing paragraphs.
[31] Pursuant to 18 U.S.C. § 982, the court in imposing a sentence on a person convicted of certain healthcare fraud offenses shall order the person "forfeit to the United States any property, real or personal, involved in such offense, or any property traceable to such property." 18 U.S.C. § 982 .
[32] The summary provided in the foregoing paragraphs related to the Anti-kickback Statute is based substantially on the U.S. Department of Health and Human Services, Office of Inspector General ("OIG") guidance to physicians, "A Roadmap for New Physicians." *See* OIG, "*A Roadmap for New Physicians; Avoiding Medicare and Medicaid Fraud and Abuse*" *at* p. 4.
[33] 42 U.S.C. § 1320a-7b [b][1][A] & [2][A].
[34] 42 U.S.C. § 1320a-7b [b][1][B] & [2][B].
[35] *Id.*

The statute covers both the payers of kickbacks (e.g. those who offer or pay remuneration), as well as the recipients of kickbacks (e.g. those who solicit or receive remuneration). Each party's intent is a key element of their liability under the AKS. Criminal penalties and administrative sanctions for violating the AKS include fines, jail terms,[36] and exclusion from participation in the Federal health care programs.[37]

Note that physicians who pay or accept kickbacks also face penalties of up to $22,363 per occurrence[38] plus three times the amount of the remuneration. Safe harbors protect certain payment and business practices that could otherwise implicate the AKS from criminal and civil prosecution. To be protected by a safe harbor, an arrangement must fit squarely in the safe harbor and satisfy all of its requirements. Some safe harbors address personal services[39] and rental agreements,[40] investments in ambulatory surgical centers,[41] and payments to bona fide employees.[42]

2) Physician Self-Referral Law, "Stark Law" (42 U.S.C. § 1395nn)[43]

The Physician Self-Referral Law, commonly referred to as the Stark law, prohibits physicians from referring patients to receive "designated health services" payable by Medicare or Medicaid from entities with which the physician or an immediate family member has a financial relationship, unless an exception applies.[44] Financial relationships include both ownership/investment interests and compensation arrangements. For example, if you invest in an imaging center, the Stark law requires the resulting financial relationship to fit within an exception or you may not refer patients to the facility and the entity may not bill for the referred imaging services.[45]

Examples of "designated health services" include: clinical laboratory services;[46] radiology and certain other imaging services;[47] radiation therapy services and supplies;[48] durable medical equipment and supplies;[49] and inpatient and outpatient hospital services.[50]

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[36] 42 U.S.C. § 1320a-7b [b][1] & [2].
[37] 42 U.S.C. § 1320a-7a [a][7].
[38] *See* 83 Fed. Reg. 3944, 3946 § "Part 85-Civil Monetary Penalties Inflation Adjustment" table under the *Civil Division*.
[39] 42 C.F.R. § 1001.952 [d].
[40] 42 C.F.R. § 1001.952 [b].
[41] 42 C.F.R. § 1001.952 [r]; *see also* 42 C.F.R. § 416.2 defines "ambulatory surgical center" as any distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization and in which the expected duration of services would not exceed 24 hours following an admission. The entity must have an agreement with CMS to participate in Medicare as an ASC. *Id.*
[42] 42 C.F.R. § 1001.952 [i] . *See also* OIG, "*A Roadmap for New Physicians; Avoiding Medicare and Medicaid Fraud and Abuse*" *at* p. 4.
[43] The summary provided in the foregoing paragraphs related to the Stark is based substantially on the OIG guidance to physicians, "A Roadmap for New Physicians." *See* OIG, "*A Roadmap for New Physicians; Avoiding Medicare and Medicaid Fraud and Abuse*" *at* p. 6.
[44] *See* OIG, "*A Roadmap for New Physicians; Avoiding Medicare and Medicaid Fraud and Abuse*" *at* p. 6.
[45] *Id.*
[46] 42 C.F.R. § 411.351, "Designated Health Services" § [1][i].
[47] 42 C.F.R. § 411.351, "Designated Health Services" § [1][iii].
[48] 42 C.F.R. § 411.351, "Designated Health Services" § [1][iv].
[49] 42 C.F.R. § 411.351, "Designated Health Services" § [1][v].
[50] 42 C.F.R. § 411.351, "Designated Health Services" § [1][x].

Note that, unlike the Anti-kickback statute, the Stark law is a strict liability statute, which means proof of specific intent to violate the law is not required.[51] The Stark law prohibits the submission, or causing the submission, of claims in violation of the law's restrictions on referrals. Penalties for physicians who violate the Stark law include fines as well as exclusion from participation in the Federal health care programs. Note that, similar to the AKS, certain Stark exceptions protect certain payments and business practices that could otherwise implicate the Stark law.[52] To be protected by an exception, an arrangement must satisfy all of the exception's requirements. Examples of exceptions include certain personal services[53] and rental agreements,[54] the academic medical center structure,[55] and payments to bona fide employees.[56]

3) Theft or embezzlement in connection with health care (18 U.S.C. § 669)

A person may be in violation of 18 U.S.C. § 669 if he knowingly and willfully embezzles, steals, or otherwise, without authority, converts to the use other than to the rightful owner, assets of a health care benefit program. Furthermore, there may be a violation if a person intentionally "misapplies any of the moneys, funds, securities, premiums, credits, property, or other assets of a health care benefit program."[57] Note that the penalty shall be a fine or imprisonment not more than 10 years, or both. Furthermore, if the value of such property does not exceed the sum of $100 the person shall be fined or imprisoned not more than one year, or both.[58]

4) Criminal Health Care Fraud Statute (18 U.S.C. § 1347)

A person is in violation of 18 U.S.C. § 1347 if he knowingly and willfully executes or attempts to execute (with or without actual knowledge or specific intent),[59] a scheme "to defraud any health care benefit program;"[60] 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, any health care benefit program, in connection with the delivery of or payment for health care benefits, items, or services."[61]

Generally, the penalty is a fine, imprisonment not more than 10 years, or both. Note that there are escalating penalties depending on certain results of the fraud. Namely, if the violation results in serious bodily injury, such person shall be fined or imprisoned not more than 20 years, or

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[51] OIG, Comparison of the Anti-kickback Statute and Stark Law, *Provider Compliance Training* A Roadmap for New Physicians, *Fraud & Abuse Laws, False Claims Act* available at: https://oig.hhs.gov/compliance/provider-compliance-training/files/starkandakscharthandout508.pdf (last accessed on September 20, 2018).
[52] *Id.*
[53] 42 C.F.R. § 411.357 [d].
[54] 42 C.F.R. § 411.357 [a].
[55] 42 C.F.R. § 411.355 [e].
[56] 42 C.F.R. § 411.357 [c]. *See also* OIG, Comparison of the Anti-kickback Statute and Stark Law, *Provider Compliance Training* A Roadmap for New Physicians, *Fraud & Abuse Laws, False Claims Act* available at: https://oig.hhs.gov/compliance/provider-compliance-training/files/starkandakscharthandout508.pdf (last accessed on September 20, 2018).
[57] 18 U.S.C. § 669.
[58] 18 U.S.C. § 669.
[59] 18 U.S.C. § 1347 [b].
[60] 18 U.S.C. § 1347 [a][1].
[61] 18 U.S.C. § 1347 [a][1].

both. [62] Furthermore, if the violation results in death, there shall be no year limitation (i.e. person can be imprisoned for any term of years or for life).[63]

5) Attempt and Conspiracy (18 U.S.C. § 1349)

Any person who attempts or conspires to commit any offense under this chapter shall be subject to the same penalties as those prescribed for the offense, the commission of which was the object of the attempt or conspiracy.[64]

6) Statements or entries generally (18 U.S.C. § 1001)

A person who knowingly and willfully: (i) "falsifies, conceals, or covers up by any trick, scheme, or device a material fact;"[65] (ii) makes any statement or representation that is "materially false, fictitious, or fraudulent;"[66] or (iii) makes or uses any false writing or document knowing it to contain any statement or entry that is "materially false, fictitious, or fraudulent statement or entry;"[67] shall be fined, imprisoned not more than 5 years, or both.[68]

7) False statements relating to health care matters (18 U.S.C. § 1035)[69]

Any person shall be in violation of this law if he knowingly and willfully (i) "falsifies, conceals, or covers up by any trick, scheme, or device a material fact;"[70] (ii) makes any statements or representations that are materially false, fictitious, or fraudulent, or (iii) knowingly makes or uses any materially false writing or document,[71] in any matter involving a health care benefit program and in connection with the delivery of or payment for health care benefits, items, or services. A person shall be fined, imprisoned not more than 5 years, or both.

8) Frauds and Swindles (18 U.S.C. § 1341)[72]

Whoever devises a scheme to defraud, or obtain money or property "by means of false or fraudulent pretenses, representations, or promises"[73] and places in any post office any matter or thing whatever to be sent or delivered by the Postal Service or any private or commercial carrier service (*e.g.*, UPS, FedEx) shall be fined, imprisoned not more than 20 years, or both.[74] Note that this law also applies to any person who takes or receives therefrom, any such matter or item.[75]

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[62] 18 U.S.C. § 1347 [a][2].
[63] 18 U.S.C. § 1347 [a][2].
[64] 18 U.S.C. § 1349.
[65] 18 U.S.C. § 1001 [a][1].
[66] 18 U.S.C. § 1001 [a][2].
[67] 18 U.S.C. § 1001 [a][3].
[68] 18 U.S.C. § 1001.
[69] 18 U.S.C. § 1035.
[70] 18 U.S.C. § 1035 [a][1].
[71] 18 U.S.C. § 1035 [a][2].
[72] Note that in United States v. Campbell, 845 F.2d 1374, 1382–83 (6th Cir. 1988) the Court found that the Defendant's conviction is based on a fraudulent scheme to obtain money from his patients and the government, and was conduct that is clearly within the traditional parameters of the offense described in section 18 U.S.C. § 1341.
[73] 18 U.S.C. § 1341.
[74] 18 U.S.C. § 1341.
[75] *Id.*

9) Fraud by Wire, Radio and Television (18 U.S.C. § 1343)[76]

Whoever, having devised or intending to devise any scheme or artifice to defraud, or for obtaining money or property by means of false or fraudulent pretenses, representations, or promises, transmits or causes to be transmitted by means of wire, radio, or television communication in interstate or foreign commerce, any writings, signs, signals, pictures, or sounds for the purpose of executing such scheme or artifice, shall be fined, or imprisoned not more than 20 years, or both.[77]

10) Obstruction of Federal Audit (18 U.S.C. § 1516)

Any person with intent to deceive or defraud the United States, endeavors to influence, obstruct, or impede a Federal auditor in the performance of official duties relating to a person, entity, or program directly or indirectly receiving in excess of $100,000 in any 1 year period under a contract or subcontract, shall be fined, or imprisoned not more than 5 years, or both.[78]

11) Obstruction of Criminal Investigations of Health Care Offenses (18 U.S.C. § 1518)

Whoever willfully prevents, obstructs, misleads, delays or attempts to prevent, obstruct, mislead, or delay the communication of information or records to a criminal investigator when it is related to a violation of a Federal health care offense can be fined, imprisoned not more than 5 years, or both.[79]

12) Laundering of Monetary Instruments (18 U.S.C. § 1956 [a][1])

Whoever conducts a financial transaction which involves the proceeds of some form of unlawful activity, "with the intent to promote the carrying on of specified unlawful activity; or…to conceal or disguise the nature, the location, the source, the ownership, or the control of the proceeds of specified unlawful activity…"[80] shall be in violation of this section. Per the statute, such person shall be sentenced to a fine of up to $500,000 or double the value of the property, whichever is greater, imprisonment for not more than twenty years, or both.[81]

13) Making or Causing to be Made False Statements or Representations (42 U.S.C. § 1320a-7b(a))

Any person is in violation of this section when he or she (i) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for

[76] *See e.g.* United States v. Bergman, 852 F.3d 1046 (11th Cir.), cert. denied, 138 S. Ct. 283, 199 L. Ed. 2d 181 (2017).
[77] 18 U.S.C. § 1343.
[78] 18 U.S.C. § 1516. *See also* 42 U.S.C. § 1320a-7a [a][9] that imposes a civil monetary penalty for any entity that fails to grant timely access to the OIG upon its reasonable request for the purpose of audits, investigations, evaluations, or other statutory OIG functions. *Id.*
[79] 18 U.S.C. § 1518.
[80] 18 U.S.C. § 1956 [a][1].
[81] *Id.*

any benefit or payment under a Federal health care program;[82] or (ii) presents or causes to be presented a claim for a physician's service for which payment may be made under a Federal health care program and knows that the individual who furnished the service was not licensed as a physician.[83] Per the statute, such person shall be guilty of a felony and upon conviction thereof fined not more than $100,000 or imprisoned for not more than 10 years or both.[84]

14) False Statements or Representations with Respect to Condition or Operation of Institutions (42 U.S.C. § 1320a-7b(c))

Whoever knowingly and willfully makes or causes to be made, or otherwise induces or attempts to induce the making of, any false statement or false representation of a material fact with respect to the conditions or operation of any institution or facility, including a hospital, critical access hospital, skilled nursing facility, home health agency, or other entity "for which certification is required under subchapter XVIII or a State health care program or with respect to information required for Medicare Part B providers" [85] shall be in violation of this section. Per the statute, such person shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than 5 years, or both.[86]

II. LAWS OF THE STATE OF CONNECTICUT

Connecticut False Claim Laws (and related laws, *e.g.*, kickback and self-referral laws) fall under the jurisdiction of both Connecticut's criminal laws with prison sentences,[87] as well as civil and administrative laws with severe civil and monetary penalties. Note that some of the crimes (e.g. larceny) listed herein apply to areas of interaction with the government and so could be applicable to health care fraud.

A. Criminal Laws

1) Medicaid Fraud. (C.G.S.A. § 53a-290 et. seq.)[88]

A person commits vendor fraud when, such person provides goods or services to a Medicaid beneficiary,[89] and does one of the following with the intent to defraud:

- submits a false claim for goods or services performed;[90]

[82] 42 U.S.C. § 1320a-7b(a)[1] .
[83] 42 U.S.C. § 1320a-7b(a)[5] .
[84] 42 U.S.C. § 1320a-7b [a].
[85] 42 U.S.C. § 1320a-7b.
[86] 42 U.S.C. § 1320a-7b.
[87] Note that an offense for which a person may be sentenced to a term of imprisonment in excess of one year is a felony. C.G.S.A. § 53a-25 . More specifically, for any felony, "the sentence of imprisonment shall be a definite sentence and, unless the section of the general statutes that defines or provides the penalty for the crime specifically provides otherwise, the term shall be fixed by the court as follows:…(4) For a class A felony, a term not less than ten years nor more than twenty-five years;…(6) For a class B felony, a term not less than one year nor more than twenty years;…(7) For a class C felony, a term not less than one year nor more than ten years;…(8) For a class D felony, a term not more than five years;…(9) For a class E felony, a term not more than three years." C.G.S.A. § 53a-35a [4], [6], [7], [8], and [9].
[88] *See also* R.C.S.A. § 17-83k-1 et. seq.
[89] 42 U.S.C. § 1396 et. seq. Note also, this section applies to vendor fraud when providing services to a beneficiary under other state assistance programs. *See* C.G.S.A. § 53a-290.

- accepts payment for goods or services performed, which exceeds (i) amounts due for goods or services performed, or (ii) the amounts authorized by law for the cost of such goods or services; [91]

- solicits to perform unnecessary services for or sell unnecessary goods to any such beneficiary; [92]

- sells goods to or performs services for any such beneficiary without prior authorization when required by the Department of Social Services; [93] or

- accepts compensation in excess of the amount authorized by law from any person or source other than the state an additional.[94]

Penalties range from a class B felony[95] (e.g. receipt of payment in excess of ten thousand dollars) to class C misdemeanor[96] (e.g. receipt of payment in the amount of two hundred fifty dollars or less) and forfeiture of privileges of participation in state assistance programs.[97]

Furthermore, note that Conn. Gen. Stat. Ann. § 17b-127 states that no vendor of goods or services sold to or performed for any beneficiary of certain state assistance programs shall "present for payment any false claim for goods or services performed, or accept payment for goods or services performed, which exceeds the amounts due for goods or services performed."[98]

2) Health insurance fraud, "Health insurance Fraud" (C.G.S.A. § 53-440, et. seq.)

A person is guilty of health insurance fraud when he, with the intent to defraud or deceive any insurer, (1) presents or causes to be presented to any insurer or any agent thereof any written or oral statement as part of or in support of an application for any policy of insurance or claim for payment or other benefit from a plan providing health care benefits, whether for himself, a family member or a third party, knowing that such statement contains any false, incomplete, deceptive or misleading information concerning any fact or thing material to such claim or

[90] C.G.S.A. § 53a-290 [1].
[91] C.G.S.A. § 53a-290 [2].
[92] C.G.S.A. § 53a-290 [3].
[93] C.G.S.A. § 53a-290 [4].
[94] C.G.S.A. § 53a-290 [5]. *See also* C.G.S.A. § 17b-127, which states, in relevant part, that "no vendor of goods or services sold to or performed for any beneficiary of assistance under sections 17b-122, 17b-124 to 17b-132, inclusive, 17b-194 to 17b-197, inclusive, 17b-263, and 17b-689b shall, with intent to defraud, present for payment any false claim for goods or services performed, or accept payment for goods or services performed, which exceeds the amounts due for goods or services performed." Also note that R.C.S.A. § 17-83k-1 promulgates the policies and procedures for Administrative Sanctions to be imposed against vendors or providers of goods or services performed for or sold to beneficiaries under said programs for violations including, but not limited to, those hereinafter set forth.
[95] *See* C.G.S.A. §53a-291.
[96] *See* C.G.S.A. § 53a-296.
[97] C.G.S.A. §17b-99 [a].
[98] C.G.S.A. § 17b-127 [a].

application, or omits information concerning any fact or thing material to such claim or application, or (2) assists, abets, solicits or conspires with another to prepare or present any written or oral statement to any insurer or any agent thereof, in connection with, or in support of, an application for any policy of insurance or claim for payment or other benefit from a plan providing health care benefits knowing that such statement contains any false, deceptive or misleading information concerning any fact or thing material to such application or claim. For purposes of this section, "misleading information" includes but is not limited to falsely representing that goods or services were medically necessary in accordance with professionally accepted standards.[99]

Any person who violates any provision of sections 53-440 to 53-443, inclusive, shall be subject to the penalties for larceny under sections 53a-122 to 53a-125b, inclusive. Each act shall be considered a separate offense. In addition to any fine or term of imprisonment imposed, including any order of probation, any such person shall make restitution to an aggrieved insurer, including reasonable attorneys' fees and investigation costs.[100]

3) Insurance Fraud. "Insurance Fraud: Class D. Felony" (C.G.S.A. § 53a-215)

A person is guilty of insurance fraud when the person knows the falsity or incompleteness of an oral or written statement (e.g. statement includes, but is not limited to, any notice, statement, invoice, account, estimate of property damages, bill for services, test result, or other evidence of loss, injury, or expense)[101] and either:

- presents or causes to be presented to any insurance company such statements "including computer-generated documents as part of, or in support of, any application for any policy of insurance or a claim for payment or other benefit pursuant to such policy of insurance, knowing that such statement contains any false, incomplete, or misleading information concerning any fact or thing material to such application or claim;"[102] or

- assists with another to prepare or make any such statement that is intended to be presented to any insurance company in connection with payment or other benefit pursuant to such insurance company's policy.[103]

Insurance fraud is a class D felony.[104]

4) Larceny (C.G.S.A. §§ 53a-122 to 53a-125b, inclusive)

[99] C.G.S.A. § 53-442.
[100] C.G.S.A. § 53-443.
[101] C.G.S.A. § 53a-215 [b].
[102] C.G.S.A. § 53a-215 [a].
[103] C.G.S.A. § 53a-215 [a].
[104] *Id.*

A person commits larceny when, with intent to deprive another of property or to appropriate the same to himself or a third person, he wrongfully takes, obtains or withholds such property from an owner.[105] Penalties for larceny range from a class B felony[106] (*e.g.*, the value of the property or service exceeds twenty thousand dollars, or the property is obtained by defrauding a public community, and the value of such property exceeds two thousand dollars) to a class C misdemeanor[107] (*e.g.*, the property or service is valued at five hundred dollars or less).

5) False Statement in the Second Degree: Class A Misdemeanor (C.G.S.A. § 53a-157b)

A person is guilty of a crime for false statement when such person (1) intentionally makes a false written statement that such person does not believe to be true with the intent to mislead a public servant in the performance of such public servant's official function, and (2) makes such statement under oath or pursuant to a form bearing notice, authorized by law, to the effect that such false statements are punishable. [108]

Note that the law defines a "public servant" as an officer or employee of government or a quasi-public agency, elected or appointed, and any person participating as advisor, consultant or otherwise, paid or unpaid, in performing a governmental function.[109]

False statement is a class A misdemeanor. [110]

6) Tampering with or Fabricating Physical Evidence (C.G.S.A. § 53a-155)

A person is guilty of tampering with or fabricating physical evidence if, believing that a criminal investigation conducted by a law enforcement agency or an official proceeding is pending, or about to be instituted, such person: "(1) Alters, destroys, conceals or removes any record, document or thing with purpose to impair its verity or availability in such criminal investigation or official proceeding; or (2) makes, presents or uses any record, document or thing knowing it to be false and with purpose to mislead a public servant who is or may be engaged in such criminal investigation or official proceeding."[111]

Tampering with or fabricating physical evidence is a class D felony.[112]

7) State Anti-Kickback, Paying a Kickback (C.G.S.A. § 53a-161d)

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[105] *See* C.G.S.A. § 53a-119.
[106] *See* C.G.S.A. § 53a-122 [a].
[107] *See* C.G.S.A. § 53a-125b[a].
[108] *See* C.G.S.A. § 53a-157b.
[109] *See* C.G.S.A. § 53a-146 [3].
[110] *See* C.G.S.A. § 53a-157b.
[111] C.G.S.A. § 53a-155 [a].
[112] C.G.S.A. § 53a-155 [b]. See also, (a) A person is guilty of false statement when such person (1) intentionally makes a false written statement that such person does not believe to be true with the intent to mislead a public servant in the performance of such public servant's official function, and (2) makes such statement under oath or pursuant to a form bearing notice, authorized by law, to the effect that false statements made therein are punishable. False statement is a class A misdemeanor. C.G.S.A. 53a-157b.

A person is guilty of paying a kickback when he knowingly offers or pays any benefit, in cash or kind, to any person with intent to influence such person to either:

- refer an individual, or to 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; or

- 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.[113]

Paying a kickback is a class D felony.[114]

B. Civil and Administrative Laws

1) State False Claims Act. "False claims and other prohibited acts re state-administered health or human services programs." (C.G.S.A. § 4-275)

This statute mirrors the Federal False Claims Act in substantial part and, among other things, makes illegal for any person to knowingly present, or cause to be presented, a false or fraudulent claim for payment or approval under a state-administered health or human services program. Similarly, no person shall knowingly make, use or cause to be made or used, a false record or statement material to a false or fraudulent claim under a state-administered health or human services program.[115]

It further prohibits any person from knowingly making, using or causing to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the state under a state-administered health or human services program.[116]

Per the statute, the penalty for violation of this section is (i) a civil fine to be adjusted from time to time by the federal Civil Penalties Inflation Adjustment Act of 1990, 28 U.S.C. 2461; (ii) three times the amount of damages that the state sustains because of the act of that person; and (iii) the costs of investigation and prosecution of such violation.[117]

2) State Stark self-referral, Billing for clinical laboratory services (C.G.S.A. § 20-7a)

[113] C.G.S.A. § 53a-161d [a].
[114] *Id.*
[115] C.G.S.A. § 4-275.
[116] *Id.*
[117] *Id.* Note that under Connecticut state law, the Commissioner of Social Services shall adopt regulations to provide a financial incentive for the reporting of vendor fraud in any program under the jurisdiction of the Department of Social Services by offering a person up to fifteen per cent of any amounts recovered by the state as a result of such person's report. C.G.S.A. § 17b-102 . RCSA promulgates the requirements for Providing Financial Incentive for the Reporting of Vendor Fraud. RCSA 17b-102-01, *et. seq.*

This state law provides a limited notification requirement in the instance where the practitioner: (1) has an ownership or investment interest in an entity that provides diagnostic or therapeutic services, or (2) receives compensation or remuneration for referral of patients to an entity that provides diagnostic or therapeutic services.[118]

Such practitioner must: (i) disclose such interest to any patient prior to referring such patient to such entity for diagnostic or therapeutic services (including include physical therapy, radiation therapy, intravenous therapy and rehabilitation services including physical therapy, occupational therapy or speech and language pathology, or any combination of such therapeutic services); and (ii) provide reasonable referral alternatives.[119]

Such information must be, at a minimum, verbally disclosed to each patient or posted in a conspicuous place visible to patients in the practitioner's office. The minimum information to be posted include the therapeutic and diagnostic services in which the practitioner has an ownership or investment interest and therapeutic and diagnostic services from which the practitioner receives compensation or remuneration for referrals and state that alternate referrals will be made upon request.[120]

Note that this subsection does not apply to in-office ancillary services. As used in this subsection, "ownership or investment interest" does not include ownership of investment securities that are purchased by the practitioner on terms available to the general public and are publicly traded; and "entity that provides diagnostic or therapeutic services" includes services provided by an entity that is within a hospital but is not owned by the hospital. [121]

A practitioner that violates this law is subject to disciplinary action under subdivision (7) of subsection (a) of section 19a-17. [122]

III. WHISTLEBLOWER PROTECTION

As set out in greater detail below, both federal and state laws provide protections for whistleblowers within the workforce from discriminatory practices by the workforce member's employer.

A. FEDERAL LAW

1) Federal False Claims Act (31 U.S.C. §3730[h])[123]

[118] C.G.S.A. § 20-7a [c].
[119] *Id.*
[120] *Id.*
[121] *Id.*
[122] *Id.*
[123] Note that, as applicable, the Pilot Program for Enhancement of Employee Whistleblower Protections (41 U.S.C. § 4712), applies to all employees working for contractors, grantees, subcontractors and subgrantees of Federal contracts and grants. More specifically, it provides protections for employees who disclose information that the employee reasonably believes is evidence of: "(i) gross mismanagement of a Federal contract or grant, (ii) a gross waste of Federal funds, (iii) an abuse of authority relating to a Federal contract or grant, (iv) a specific danger to public health or safety, or (v) a violation of law, rule, or regulations related to a Federal contract or grant. The statute provides that employees who make such disclosures may not be discharged, demoted or otherwise discriminated against."[123]

The Federal False Claims Act provides protection to *qui tam* relators (individuals who commence a False Claims action) who are discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of their employment as a result of their furtherance of an action under the FCA. 31 U.S.C. § 3730(h). Remedies include reinstatement with comparable seniority as the *qui tam* relator would have had but for the discrimination, two times the amount of any back pay, interest on any back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees.[124]

B. STATE OF CONNECTICUT PROTECTIONS

1) Protection of Employees Who Discloses Employer's Illegal Activities or Unethical Practices. (C.G.S.A. § 31-51m)

No employer shall discharge, discipline or otherwise penalize any employee because (1) the employee, or a person acting on behalf of the employee, reports, verbally or in writing, a violation or a suspected violation of any state or federal law or regulation or any municipal ordinance or regulation to a public body, (2) the employee is requested by a public body to participate in an investigation, hearing or inquiry held by that public body, or a court action.[125]

The provisions of this subsection shall not be applicable when the employee knows that such report is false.[126]

Any employee who is discharged, disciplined or otherwise penalized by his employer may bring a civil action within ninety days of the date of the final administrative determination or within ninety days of such violation, whichever is later. The employee could, through the civil action, request reinstatement of his previous job, payment of back wages and reestablishment of employee benefits to which he would have otherwise been entitled if such violation had not occurred.[127] Note that any employee found to have knowingly made a false report shall be subject to disciplinary action by his employer up to and including dismissal.[128]

2) Discriminatory Practices Prohibited (C.G.S.A. § 19a-498a)

C.G.S.A. § 19a-498a prohibits discriminatory practices such as "the discharge, demotion, suspension, or any other detrimental changes in terms or conditions of employment, or the threat

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[124] *See* 31 U.S.C. § 3730[h].
[125] C.G.S.A. § 31-51m [a]. *See also* C.G.S.A. § 4-61dd (a) where it states that "any person having knowledge of any matter involving corruption, unethical practices, violation of state laws or regulations, mismanagement, gross waste of funds, abuse of authority or danger to the public safety occurring in any state department or agency, any quasi-public agency, as defined in section 1-120, or any Probate Court or any person having knowledge of any matter involving corruption, violation of state or federal laws or regulations, gross waste of funds, abuse of authority or danger to the public safety occurring in any large state contract, may transmit all facts and information in such person's possession concerning such matter to the Auditors of Public Accounts. The Auditors of Public Accounts shall review such matter and report their findings and any recommendations to the Attorney General." *Id.*
[126] C.G.S.A. § 31-51m [a].
[127] *Id. See also* R.C.S.A. § 4-61dd-1.
[128] *Id. See also* R.C.S.A. § 4-61dd-1.

of any such actions" against any employee of a health care facility because said affected employee:

- Submitted a compliant to a governmental entity relating to the care or services by or the conditions in, such facility;
- Initiated an investigation by or a proceeding before a governmental entity relating to the care or services by or the conditions in, such facility; and
- Cooperated in an investigation by or a proceeding before a governmental entity relating to the care or services by or the conditions in, such facility.[129]

Any employee that has faced these prohibited practices are entitled to seek reinstatement and reimbursement "for lost wages, lost work benefits, and any reasonable legal costs incurred by the employee in pursuing the employee's rights under [CGS § 19a-498a]."[130] Further, affected employees may seek any additional remedies available to them under applicable Federal or State law.[131]

3) Whistleblower Protection for Foundation Employees. (C.G.S.A. § 4-37j)

Each foundation[132] shall develop, in conjunction with the Auditors of Public Accounts, and implement a written policy (1) for the investigation of any matter involving corruption, unethical practices, violation of state laws or regulations, mismanagement, gross waste of funds, abuse of authority or danger to the public safety occurring in such foundation, (2) prohibiting any officer or employee of the foundation from taking or threatening to take any personnel action against any foundation employee who transmits information concerning any such matter, (3) providing that any foundation employee who is found to have knowingly and maliciously made false charges shall be subject to disciplinary action by the employee's appointing authority, up to and including dismissal, and (4) requiring the foundation to provide a copy of such policy to its employees and to periodically notify the employees of the existence of the policy.[133]

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[129] C.G.S.A. § 19a-498a [a-b]. Note, for purposes of C.G.S.A. § 19a-498a, the term "health care facility" includes, without limitation, hospitals licensed by the Connecticut Department of Health, outpatient surgical facilities, and free standing emergency departments, as well as "any parent company, subsidiary, affiliate or joint venture, or combination thereof, of any such facility." C.G.S.A. § 19a630 [11]; *see also* C.G.S.A. §19a-498a [a].

[130] C.G.S.A. §19a-498a [c].

[131] *Id*. at §19a-498a [d].

[132] C.G.S.A. § 4-37e [2]. "Foundation" means an organization, fund or any other legal entity which is (A) exempt from taxation pursuant to Section 501(c)(3) of the Internal Revenue Code of 1986, or any subsequent corresponding internal revenue code of the United States, as from time to time amended, and (B) established for the principal purpose of receiving or using private funds for charitable, scientific, cultural, educational or related purposes that support or improve a state agency or for coordinated emergency recovery purposes. Such an organization, fund or other legal entity shall not be deemed to be a state agency or a public agency, as defined in section 1-200. *Id.*

[133] C.G.S.A. § 4-37j .

4) Liability of Employer for Discipline or Discharge of Employee on Account of Employee's Exercise of Certain Constitutional Rights. (C.G.S.A. § 31-51q)

Any employer, including the state, who subjects any employee to discipline or discharge on account of the exercise by such employee of rights guaranteed by the first amendment to the United States Constitution or the Constitution of the state, provided such activity does not substantially or materially interfere with the employee's bona fide job performance or the working relationship between the employee and the employer, shall be liable to such employee for damages caused by such discipline or discharge. Such damages could include punitive damages and reasonable attorney's fees as part of the costs of any such action for damages. If the court determines that such action for damages was brought without substantial justification, the court may award costs and reasonable attorney's fees to the employer.[134]

5) Other State Whistleblower laws

Pursuant to Conn. Gen. Stat. Ann. § 17b-25a, the Commissioner of Social Services ("DSS") must provide a toll-free telephone number for a person to report vendor fraud in any program operated by the Department of Social Services. The DSS hotline is 1-800-842-2155 and the on-line client complaint form can be found here: https://portal.ct.gov/DSS/Quality-Assurance/To-Report-Fraud-or-Abuse-of-Programs.

[134] C.G.S.A. § 31-51q.