Connecticut False Claims Act: A New Arrow in the Quiver of State Regulators

On October 5, 2009, Governor Rell signed a civil False Claims Act into law. Connecticut’s False Claims Act (CFCA) is modeled after the federal False Claims Act, a Civil War era statute originally enacted to prosecute profiteers engaged in fraud against the Union Army. The False Claims Act is now the federal government’s primary and powerful statutory tool to combat fraud, waste and abuse, particularly in the Medicare and Medicaid programs.

The new Connecticut statute has the potential to become an equally potent tool for state authorities to combat fraud and abuse. The law was enacted through the Department of Social Services (DSS) biennial budget implementation legislation, Public Act 09-5 September Special Session, and became effective when it was signed by the governor. Unlike the federal False Claims Act, which applies broadly to any false claim submitted to the federal government, the Connecticut law applies more narrowly and only to the medical assistance programs administered by DSS including: Medicaid, State-Administered General Assistance (SAGA), HUSKY B, and Charter Oak.

According to the United States Health and Human Services Office of Inspector General (OIG) website, at least 20 states have already enacted false claims acts. The federal Deficit Reduction Act of 2005 (DRA), provided an incentive for states to enact false claims laws: namely, the retention of 10% of the federal Medicaid share of any funds recouped in a Medicaid fraud action.

This advisory summarizes the CFCA, highlights the Act’s implications for Connecticut health-care providers, and suggests compliance pointers.

Summary of the Connecticut False Claims Act: Civil Monetary Penalties and Incentives for Whistleblowers

Prohibited False Claims.—The CFCA prohibits “any person,”—defined as an individual or an organization,—from knowingly presenting (or causing to be presented) a false or fraudulent claim for payment or approval under the medical assistance programs administered by DSS, or knowingly making (or causing to be made) a false statement in order to get such a claim approved, or, knowingly concealing, avoiding or decreasing any obligation to pay or transmit money or property to the state. The prohibition extends to a conspiracy, that is, an unlawful agreement between two or more persons, to defraud the state. The CFCA requires “knowing” conduct. “Knowing” conduct may be found where a person or entity consciously avoids learning relevant facts (“deliberate ignorance”) or acts in “reckless disregard” of relevant facts.

Penalties.—The CFCA’s penalties can be severe. Civil penalties can range from $5,000 to $10,000 per violation. Like the federal False Claims Act, the CFCA also authorizes recovery of up to three times the damages sustained by the state as a result of the false claim. The defendant must also pay the costs of investigation and prosecution of the state’s claim. These penalties often multiply quickly, and even a relatively minor violation can have significant financial implications.

Mitigated Penalties for Self-Reporting and Cooperation.—The CFCA rewards self-policing, self-reporting and cooperation with state investigations by authorizing a reduction in the treble damages provision to “not less than” double damages, provided certain conditions are met. Specifically, to qualify for double damages, the person or entity committing a violation of the CFCA must provide state officials responsible for investigating false claims violations with all information known to that person or entity about the violation within 30 days after the date the information about a false claim was first obtained, or otherwise became known. In addition, the person or entity making the disclosure must fully cooperate with the state’s investigation. The person or entity making a self-disclosure does not qualify for the mitigated penalties if a civil, criminal or administrative action relating to the matter had been commenced at the time the person or entity brought the information to the state’s attention.

Connecticut Attorney General’s Authorization.—The Connecticut Attorney General is authorized to investigate alleged violations of the CFCA. Information gathered pursuant to a CFCA investigation is exempt from disclosure under the Freedom of Information Act. If the Attorney General’s investigation determines that a false claim has been made, the Attorney General is authorized to bring a civil action in the Superior Court for the Judicial District of Hartford.
**Whistleblower Incentives.**—Like the federal False Claims Act, the CFCA permits private individuals (referred to as “whistleblowers” or “qui tam realtors”), to initiate civil actions under the Act. Whistleblower-initiated actions must be filed under seal and cannot be served on the alleged violator for at least 60 days, during which time the Attorney General must decide whether the state will join the case and prosecute the alleged violation.

The CFCA includes incentives to encourage whistleblowers. These incentives include:

- If the Attorney General decides to proceed with the case and the court awards civil penalties or damages to the state, or if the Attorney General settles and receives civil penalties or damages, the whistleblower may receive up to 15% to 25% of the state’s recovery. The whistleblower may also recoup the costs of any reasonable expenses that the court finds were necessarily incurred, including reasonable attorney’s fees; the defendant is responsible for paying these costs and fees. The whistleblower’s percentage share of recovery proceeds may vary depending on the court’s determination as to the whistleblower’s contribution to the action and on whether the action was based primarily on publicly disclosed information.

- If the Attorney General declines to proceed with the case, the whistleblower has the right to prosecute the action. If the whistleblower prevails, the whistleblower may recover 25% to 30% of the state’s recovery, based on the court’s determination of the extent to which the whistleblower substantially contributed to prosecution of the action. The whistleblower may also recoup the costs of any reasonable expenses that the court finds were necessarily incurred, including reasonable attorney’s fees, which the defendant must pay.

- The Act protects whistleblowers from workplace retaliation. Any employee who is discriminated against by his or her employer in retaliation for the employee’s activities in bringing an alleged false claim to light is entitled to all relief necessary to “make the employee whole,” including reinstatement, compensation for special damages, litigation costs, attorneys’ fees, and double back pay.

If the party against whom the false claim is alleged prevails, and the court finds that the claim was clearly vexatious or brought primarily to harass the defendant, then the whistleblower may be ordered to reimburse the defendant for the costs of defending the action, including attorneys fees.

**Public Disclosure Bar.**—The CFCA provides that the court has no jurisdiction over a false claims action that is based on “public disclosure of allegations or transactions” 1) in a criminal, civil or administrative hearing; 2) in a report, hearing, audit or investigation conducted by the General Assembly (including a Committee of the General Assembly), auditors of public accounts, state agency or quasi-public agency; or 3) from the news media, unless the action is brought by the Attorney General, or the whistleblower is the “original source” of the information. “Original source” means “an individual who has direct and independent knowledge of the information on which the allegations are based and has voluntarily provided the information to the state” before filing an action under the CFCA.

**Time Limits on Bringing Claims.**—CFCA actions cannot be initiated more than six years after the date the violation occurs, or more than three years after the date when a state official knew or should have reasonably known about the violation, but in no event more than 10 years after the date that the violation occurs.

**Implications for Connecticut Health-Care Providers: Heightened Enforcement**

The CFCA will likely encourage heightened civil enforcement of fraud, waste and abuse in state health-care programs. Until the recent enactment of the CFCA, the Attorney General’s Health Care Fraud Unit was hobbled in its enforcement efforts because its primary statutory enforcement tool was to initiate an administrative action under Connecticut General Statutes § 17b-99 and Conn. Agency Regs. § 17-83k-1 et seq. to seek restitution and/or exclusion of the provider from Medicaid or other state programs. Now, the CFCA gives the Attorney General a powerful statute to pursue fraud and abuse and encourages private parties to report fraud and abuse by providing a financial incentive for such reporting. Health-care providers are well-advised to expect heightened enforcement efforts with respect to alleged false claims in the health-care area.

There are unresolved issues pertaining to Connecticut’s new False Claims Act. Some of these unresolved issues include:

- **OIG Approval for Incentives.**—As discussed above, the DRA permits states with false claims statutes to retain 10% of the federal share of any amounts recovered in a case prosecuted under the state false claims statute. A state may qualify for its incentive only if its false claim law meets certain criteria, and is approved by the OIG. Of the 20 states that have false claims act statutes and that have requested OIG review, the OIG has approved 14 to share in recoveries. We do not know at this time whether
the OIG will recognize the CFCA for purposes of the 10% recovery incentive. If it does, it is a safe bet that in these tight budgetary times, state officials will be incentivized to vigorously investigate and pursue fraud and abuse.

- **Coordination with Federal Enforcement.**—Federal False Claim Act cases often involve payments under both Medicare and Medicaid. It remains to be seen how cases involving allegations of false claims implicating both federal and state programs will be handled and coordinated between and among federal and state authorities. The enactment of the CFCA can surely lead to parallel investigations conducted by federal and state authorities, complicating both the defense of such investigations and the ability to resolve them. Thankfully, federal and state authorities in Connecticut have a history of working together when there is parallel jurisdiction. Hopefully this pattern will continue when matters are investigated under this new statutory provision.

Heightened state enforcement will not occur in a vacuum; the federal government has noticeably expanded enforcement efforts as well. Over the last several years, federal authorities have indicated that health care fraud enforcement efforts will increase, and public outcry over health-care spending, particularly the wasteful spending caused by false or fraudulent claims, has further fueled these efforts. The DRA expanded funding to combat Medicaid fraud. Most recently, Congress amended the federal False Claims Act to broaden its use in federal enforcement actions. In particular, the amendments to the federal False Claims Act expand liability for knowingly retaining Medicare or Medicaid overpayments or avoiding an obligation to return an overpayment, even when no affirmative fraud has been committed.

**Recommended Action:**

**Update and Strengthen Compliance Programs**

Health-care providers should take the following steps in light of the new Connecticut False Claims Act:

- Amend compliance programs to reference the new Connecticut False Claims Act.

  - Providers that are required to comply with the DRA must amend their compliance materials to reference the CFCA. The DRA requires that providers receiving $5 million or more in Medicaid payments implement specific compliance program policies directed at preventing fraud and false claims. More particularly, the DRA requires that compliance programs include a summary of any state false claims act, if applicable, in their policies and procedures. Now that Connecticut has a False Claims Act, providers that are required to comply with the DRA must amend their compliance program policies and procedures to include a summary of the CFCA.

  The DRA does not impose penalties on providers that fail to meet these basic requirements, but these requirements must be met as conditions of participation in the Medicaid program. In addition, DSS issued regulations in 2007 that mirror the DRA’s requirements and now require nursing facilities that meet the $5 million DRA threshold to submit an affidavit attesting that the organization has satisfied the DRA’s requirements. DSS has incorporated reviews of DRA compliance into its audits of Medicaid providers.

  - Even those providers that are not required to comply with the DRA should generally review their compliance programs and their employee policies and procedures and include references to the CFCA wherever applicable. For example, any employee anti-retaliation policies should also specifically reference the CFCA’s provision prohibiting retaliation for an employee’s involvement in a false claim act action.

- Review and audit the effectiveness of your compliance programs.

  - Compliance Programs Could Become Mandatory.—Although compliance programs are still strictly voluntary, it is becoming a standard “best practice” for health-care providers to have a compliance program in place, and compliance programs soon could become mandatory. New York State now requires that all participating Medicaid providers implement compliance programs that meet specified requirements. Moreover, health-care reform proposals include provisions mandating compliance programs for health-care providers. For example, as of this writing, the America’s Healthy Future Act, the new federal health-care reform bill proposed by the United States Senate Committee on Finance, requires Medicare and Medicaid providers and suppliers to implement compliance programs as a condition of participation.

- An Effective Compliance Program Can Strengthen Your Position.—Health-care providers under investigation or defending false claims allegations will be in a stronger position if they have effective compliance programs in place. In defending allegations of “reckless disregard” or “deliberate ignorance,” the provider can point to good-faith efforts to audit and monitor for fraud and abuse through the compliance program. When it comes
to negotiating settlements, the existence of an effective compliance program can also help providers avoid integrity agreements and mitigate penalties.

- **Leaving Your Compliance Program on the Shelf is Risky Business.**—Providers with compliance programs that exist on paper only could face greater risks. To be effective, a compliance program must include active training, auditing and monitoring. If the organization does not implement these vital compliance program elements, then it will not be in a position to proactively identify and correct compliance issues to avoid serious organizational risks. Moreover, if the state investigates an allegation of fraudulent billing or other wrongdoing and discovers that a provider never followed its own compliance program's auditing requirements, the failure to carry out the compliance program could be used against the provider, either to establish CFCA liability, or to impose harsher penalties and corporate integrity requirements.

- **Now Is the Time to Refresh and Activate Your Compliance Program.**—Given the real possibility of heightened enforcement efforts, health-care providers should take the time now to conduct a fresh review of their compliance programs. It is most important that compliance programs include all of the basic elements: 1) support and involvement at the highest levels of the organization, including the board of directors; 2) appointment of a compliance officer and compliance committee; 3) implementation of written standards of conduct, policies and procedures; 4) effective means of communication through hotlines or other vehicles for making anonymous reports; 5) training and education; 6) regular auditing and monitoring activities; 7) disciplinary policies; 8) timely and effective responses to detected issues (including the return of overpayments to payors); and 9) checking to ensure that employees and contractors have not been excluded from state and federal health-care programs. All compliance program activities—whether training and education, auditing, board presentations, hotline reports, compliance committee minutes, or returning overpayments to payors—should be documented.

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