Advisory
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New Law Adds More Muscle to Connecticut False Claims Act

On June 13, 2011, Governor Malloy signed into law extensive amendments aimed at bolstering Connecticut's False Claims Act ("CFCA"). The amendments, which are contained in § § 153 through 159 of Public Act No. 11-44, broaden the CFCA's scope in several respects. Significantly, the amendments mirror the expansion of the federal False Claims Act ("FCA") and now cover so-called "reverse false claims," that is, the failure to return overpayments as a potential grounds for CFCA liability. The amendments also strengthen the CFCA's enforcement provisions and expand the law's whistleblower protections.

This Advisory describes the 2011 CFCA amendments, summarizes the key provisions, and recommends steps that health care providers should take to strengthen their compliance programs and to avoid exposure given the expanded reach of the CFCA.

Purpose of Amendments: Qualification for Federal Incentives

The federal Deficit Reduction Act of 2005 ("DRA") provided a financial incentive to encourage states to enact state false claims laws. The enactment of such a law is a prerequisite to a state's ability to retain 10% of the federal Medicaid share of any funds recouped in a Medicaid fraud action. In order to qualify for this incentive, a state must obtain a determination from the United States Department of Health and Human Services' Office of Inspector General (the "OIG"), in consultation with the U.S. Department of Justice (the "DOJ"), that the state's false claims law meets certain requirements. The state law must: (1) establish liability to the state for false or fraudulent claims with respect to Medicaid spending; (2) contain provisions that are at least as effective in rewarding and facilitating qui tam actions for false or fraudulent claims as those described in the FCA; (3) include a requirement for filing an action under seal for sixty days with review by the State Attorney General; and (4) establish a civil penalty that is not less than the amount of the civil penalty authorized under the FCA.

Enacted in 2009, the CFCA, which is codified at Connecticut General Statutes §§ 17b-301 through 17b-301p, was modeled generally after the federal False Claims Act. Unlike the FCA, which applies broadly to any false claim submitted to the federal government, the CFCA applies only to the medical assistance programs administered by the Connecticut Department of Social Services ("DSS"), including Medicaid. The CFCA prohibits individuals and organizations that receive payments from a state medical assistance program from knowingly presenting, or causing to be presented, a false or fraudulent claim for payment. Like the federal False Claims Act, the CFCA provides for civil penalties, including treble damages, and also authorizes whistleblower or qui tam actions.

In 2009 and 2010, Congress enacted amendments to the federal False Claims Act, including provisions contained in the Fraud Enforcement and Recovery Act of 2009 ("FERA"), the Patient Protection and Affordable Care Act ("PPACA"), and the Dodd-Frank Wall Street Reform and Consumer Protection Act (the "Dodd-Frank Act"). According to the OIG, these three acts significantly amended the bases for liability in the FCA and expanded certain rights of qui tam relators.

In March 2011, the OIG announced that it would not qualify a state false claims act to share in fraud recoveries unless the state law included provisions equivalent to the newly amended FCA. In fact, on March 21, 2011, the OIG issued a letter to the Connecticut Attorney

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General, George Jepsen, informing him that Connecticut would not qualify for the 10% incentive provision based on Connecticut's then existing false claims act statute. The OIG explained that the CFCA, at that time, did not measure up to the federal standard because it did not include the changes made to the FCA by FERA, PPACA, and the Dodd-Frank Act. As a result, the Connecticut General Assembly enacted Public Act No. 11-44 to amend the CFCA to ensure that it conforms to federal requirements so that Connecticut was not disqualified from the 10% incentive provision.

Summary of Amendments:

Public Act No. 44-11 broadens the circumstances under which a person or entity can be found liable for submitting false or materially misleading information in order to obtain or keep state medical assistance funds. It also increases penalties for violations of the CFCA, and expands whistleblower protections.

Expanded Liability:

- **Definition of a "claim."** Section 153 of Public Act No. 11-44 amended the CFCA's definition of a "claim," to make it clear that the CFCA covers false claims whether or not the state has actual title to the money or property at issue and even if the claim is submitted to a state contractor, so long as the money or property is to be spent or used on the state's behalf or to advance a state program or interest, and the state has provided or will provide any portion of the money or property that is requested or demanded. The Public Act also explains that this definition does not include a request or demand for money or property that the state has paid to an individual as compensation for state employment or as an income subsidy with no restrictions on that individual's use of the money or property.

- **Reverse false claims.** One of the most significant changes made by FERA to the FCA was the explicit codification of the prohibition on "reverse false claims," or the improper retention of money or property that is owed to the government, such as an overpayment. Section 154 of Public Act No. 11-44 adds a new prohibition to the CFCA: knowingly concealing or knowingly and improperly avoiding or decreasing an obligation to pay or transmit money or property to the state. This amendment is intended to track the reverse false claims provision found in the FCA.

  Section 153 of Public Act No. 11-44 also amends the definition of "obligation," to be consistent with federal law. "Obligation" is now defined as an "established duty," whether fixed or not, arising from an express or implied contractual or grantor-grantee or licensor-licensee relationship, a fee-based or similar relationship, statute or regulation, or the retention of an overpayment. These provisions make it clear that state false claims act liability can be imposed for the failure to refund overpayments. Given the reverse false claims provisions of the 2009 FERA amendments and PPACA's mandate that health care providers report and return overpayments within sixty days after they are identified, there is no doubt that returning overpayments, whether Medicare or Medicaid, is now mandatory. Medicaid providers now face the potential of both federal and state false claims liability for failing to return Medicaid overpayments.

- **Materiality standard.** The prior version of the CFCA prohibited knowingly making, using or causing to be made or used, a false record or statement to secure payment or approval of a claim. Section 154 of Public Act No. 11-44 removes the requirement that the false record or statement be made in order to secure payment or approval of the claim. It requires only that a false record or statement be "material" to the state's payment or approval of the claim.

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Like FERA, the amended CFCA now defines "materiality" as having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property. The addition of this more expansive materiality standard broadens the sweep of the CFCA by eliminating the need to show that the false record or statement was made in order to secure payment or approval. All that is required now is proof that the false record or statement was capable of influencing the payment of the claim.

- **Presentment.** As amended by Section 153 of Public Act No. 11-44, the CFCA now prohibits knowingly presenting, or causing to be presented, a false or fraudulent claim for payment or approval. The prior version of the CFCA only prohibited knowingly presenting, or causing to be presented, claims submitted to state officers or employees. This change mirrors the amendment to the FCA by FERA by removing the requirement that the claim be presented to an officer or employee of the state and makes it clear that submitting false claims to government contractors also may constitute a violation of the law.

- **Conspiracy.** The prior version of the CFCA only prohibited conspiring to "defraud the State by securing the allowance or payment of a false or fraudulent claim." Public Act No. 11-44 amended the law to more broadly prohibit conspiracy to violate the CFCA.

- **Statute of limitations.** As with the federal False Claims Act, the CFCA states that a false claims act action may not be brought more than six years after the date on which the violation is committed or more than three years after the date when facts material to the right of action are known or reasonably should have been known by the official of the state charged with responsibility to act in the circumstances, but in no event more than ten years after the date on which the violation is committed, whichever last occurs. Section 159 of Public Act No. 11-44 adds a provision to the CFCA stating that, for statute of limitations purposes, any government complaint that is filed to intervene in a qui tam action relates back to the filing date of the relator's complaint.

Increased Penalties:

- **Penalties.** Public Act No. 11-44 increases the penalties for any CFCA violation from between $5,000 and $10,000 to between $5,500 and $11,000, or as adjusted from time to time by federal law.

Expanded Whistleblower Protections:

- **Whistleblowers.** Consonant with changes made by FERA and the Dodd-Frank Act, Section 158 of Public Act No. 11-44 amends the CFCA and expands whistleblower protections. Those protections now apply not only to employees, but to contractors and agents as well. In addition, the new law establishes a three year limitations period for bringing a suit alleging an adverse job action as a result of participating in a CFCA investigation or claim.

Recommendations: Compliance Action Steps

Public Act No. 11-44 took effect on June 13, 2011 when it was signed by Governor Malloy. Although the Act made significant changes to the CFCA, these changes likely are familiar to many providers since they are already part of the federal FCA. But with more muscle on the CFCA, health care providers can expect heightened state enforcement actions on top of intensifying federal enforcement efforts.

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United States Attorney for the District of Connecticut, David Fein, and Connecticut Attorney General, George Jepsen, recently demonstrated that they will collaborate in false claims actions that affect both federal and state health care programs. On July 27, 2011, Fein and Jepsen issued a joint press release announcing a civil settlement with Walgreens for alleged violations of both the federal FCA and the CFCA, among other federal and state laws. Walgreens, without admitting any liability, agreed to pay $140,000 to settle allegations that it fraudulently submitted bills to both the Medicaid and the ConnPACE programs for prescription drugs. Specifically, the government contended that Walgreens submitted duplicate claims to Medicare and Medicaid for the cost of prescription drugs provided to individuals who were dually eligible for Medicare Part D as the primary payor and Medicaid or ConnPACE as the secondary payor. The government further contended that Walgreens failed to implement adequate controls to identify that it was getting paid twice for the same claims. The billing errors were first detected by the Department of Social Services' pharmacy service unit and confirmed during the DSS audit process.

Health care providers should take this opportunity to review, update, and strengthen their compliance programs. Specific steps that can be taken include:

- **Amend Deficit Reduction Act policies/procedures, notice and other compliance materials to reflect these recent amendments to the CFCA.**
- **Revise compliance program policies and procedures to address the obligation to report and return overpayments.** In light of the government's recent emphasis on reverse false claims, including PPACA's requirement to report and return overpayments within sixty days of identification, providers should take special care that their compliance programs have the appropriate mechanisms in place to ensure that overpayments from federal and state programs are identified and refunded on a timely basis. These steps should include policies and procedures requiring that overpayments discovered as a result of compliance audits, internal investigations, or the correction of billing errors are reported and refunded within sixty days.
- **Regularly review and reconcile credit balances.** Given the Walgreens' settlement, health care providers should ensure that they regularly review and reconcile Medicare and Medicaid credit balances and take other reasonable steps to refund duplicate payments.
- **Audit compliance program effectiveness.** Health care providers should regularly review and modify their compliance program policies and procedures and refresh compliance training to ensure that the compliance program is effective in deterring, identifying, and responding to compliance issues. Providers that find themselves under investigation or defending false claims allegations will be in a stronger position with effective compliance programs in place. In defending allegations of false claims act liability based on "reckless disregard" or "deliberate ignorance," the provider can point to good faith efforts to audit and monitor for fraud and abuse through its compliance program. When it comes to negotiating settlements, the existence of an effective compliance program can also help mitigate penalties and avoid integrity agreements.