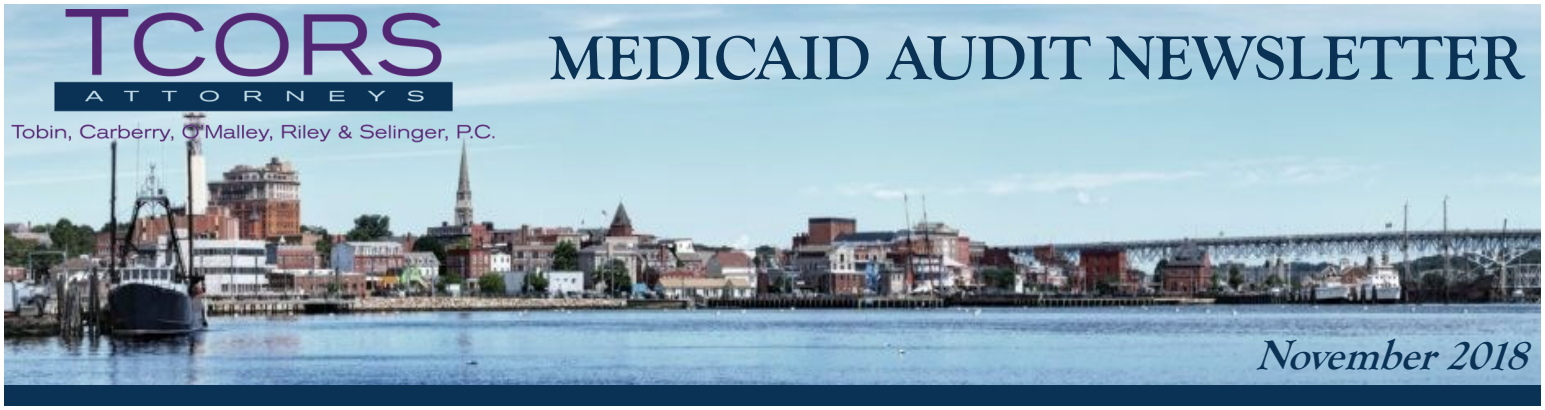

RECENT CASES UNDER STATE OF CONNECTICUT FALSE CLAIMS ACT

In light of recent False Claims Act lawsuits and settlements between the State of Connecticut and four behavioral health providers, Connecticut Medicaid providers should be keenly aware of Connecticut's False Claims Act (CFCA), the potential liability it can impose for fraudulent billing practices and the need for robust compliance and self-audit programs.

In June of 2018, the State of Connecticut reached a settlement of a lawsuit against a Waterbury behavioral health provider alleging the provider engaged in a long-term scheme to defraud Connecticut's Medicaid program. In addition to a $200,000 fine, the settlement excludes these providers from participation in the Connecticut Medicaid program for a decade. The State alleged that many of the psychotherapy services billed were either never rendered or were provided by unlicensed individuals. The State further alleged that the provider had "upcoded" services. The practice of upcoding occurs when a provider knowingly uses a higher paying code on the claim form to reflect the use of a more expensive service, procedure or device than was actually used or was medically necessary.

Also, in June of 2018, the State initiated a False Claims Act, breach of contract lawsuit against a Norwich behavioral health provider, who is accused of billing the State's Medicaid program for services not provided. The lawsuit also alleges that the provider tried to conceal the scheme by failing to maintain required records or destroying records in violation of the requirement that patients be given notice before their records are destroyed and in breach of the provider's CMAP provider agreement with the State.

In July of 2018, the State entered a joint state-federal False Claims Act settlement with a Waterford Behavioral Health Provider, resolving allegations that a Waterford psychologist submitted false claims for behavioral health services she never provided. In addition to submitting claims for services not rendered, the government also alleged that the provider had "upcoded" services. In addition to a $126,760 fine, this provider has been suspended from participation in the Connecticut Medicaid program for a period of two years.

Also in July of 2018, the State reached a False Claims Act settlement with a Norwich Behavioral Health practice. The State alleged the provider submitted claims for payment for behavioral health services purportedly performed by licensed behavioral health clinicians when, in fact, the services were rendered by unlicensed individuals employed by the provider. The provider agreed to a $300,000 settlement.

The Connecticut False Claims Act

The CFCA largely tracks the Federal False Claims Act (FCA) with the major limitation that Connecticut's version only addresses attempts to defraud the state through medical assistance programs; the FCA, on the other hand, is a generalized anti-fraud measure.

The CFCA prohibits knowingly submitting or causing to be submitted a false or fraudulent claim for medical assistance to the Department of Social Services (DSS), or submitting any false record or statement in support of such a claim. Summaries of the foregoing cases provide examples of what the State of Connecticut considers to be a false claim. Note the difference between the element of knowledge or intent, in comparison to unintentional overpayments that must be returned. Pursuant to the CMS 60-day rule.

The CFCA provides civil penalties for:

- Improperly certifying receipts of property to be used by DSS;
- Delivering less property than was purchased by DSS;
- Taking or buying property from DSS officials not authorized to sell or give it;
- Falsifying any records or making any false statements regarding payments to the state's medical assistance programs;
- Concealing, avoiding, or decreasing amounts properly owed;
- Conspiring to commit any of the above.

Typical examples of fraud include billing for services not rendered; upcoding; receiving kickbacks; or billing non-covered services.

Conducting False Claims Actions

The State Attorney General is empowered to investigate and bring civil actions for violations of the CFCA. The CFCA also allows, and encourages, individuals who have knowledge of a violation, whistleblowers (known as "relators") of the CFCA to bring civil actions. These "qui tam" actions and are usually brought by current or former employees of a medical provider. Such a complaint remains under seal for at least 60 days.

The Attorney General may in his or her discretion, take over a relator's case, and allow the relator to continue as a party to the action. The Attorney General or the defendant party may request that the court limit the relator's participation in the action in regard to such matters as calling witnesses, cross-examination, or other elements of the ligation.

If the Attorney General declines to take over a relator's qui tam action, he or she must notify the court and the relator may conduct the action alone on behalf of the state.

A. First to File and Public Disclosure Limitations

The relator must be the first to file the qui tam action; in other words, once an action is brought, no other person may intervene or bring another action based on the same facts.

The relator must also be the original source to receive a full award. If the court finds that the action was based on disclosures from a criminal, civil, or administrative hearing, a report, audit or investigation conducted by the General Assembly, Auditors of Public Accounts, or a state agency or quasi-state agency, or the news media, the court may, in its discretion, limit the relator's award, but in no case may it award the relator more than 10% of the proceeds of the action.

B. Statute Of Limitations

CFCA cases, including qui tam actions, may not be brought more than 6 years from the date of the violation, or more than 3 years from the date state officials should have had knowledge of the violation, whichever is later, but in no event more than 10 years after the date of the violation.

C. Unclean Hands

A court may reduce the award the relator receives if it finds that the relator "planned and initiated the violation". If the relator is convicted of criminal conduct for the false claims act violation, the relator will receive none of the proceeds.

Monetary Awards for Qui Tam Relators

If the relator's qui tam action is settled or successfully litigated by the Attorney General, the relator is entitled to between 15% and 25% of the proceeds, including penalties and damages. Such relator is also entitled to an amount for reasonable expenses, attorneys' fees, and costs. If the Attorney General declined to intervene and the relator wins or settles the qui tam action, the relator is entitled to an even greater award, between 25% to 30 % of the proceeds recovered.

Protections for Relators

The CFCA provides protections for relators who come forward with qui tam actions. It grants relief to any employee "who is discharged, demoted, suspended, threatened, harassed" or "discriminated against" for bringing a qui tam action, including reinstatement, two times back pay with interest, and damages, including litigation costs and reasonable attorneys' fees.

The Affordable Care Act and Medical Fraud

The Affordable Care Act (ACA) includes new provisions related to medical fraud. It instructs the Secretary of Health and Human Services (HHS) to share data with other agencies, including the Social Security Administration and Veteran Affairs Administration, "for the purpose of identifying potential fraud, waste, and abuse" in the government's medical assistance programs, such as Medicare and Medicaid.

It also empowers the Inspector General of HHS to obtain any information from any individual or entity that is a medical provider, grant recipient, supplier, contractor, or any such individual or entity that makes, distributes, or receives medical supplies or services payable by any federal health care program. This includes supporting documentation necessary to validate claims under federal and joint federal and state medical assistance programs.

If any individual eligible to receive care knowingly participates or conspires to participate in a federal health care fraud offense, the ACA allows the Secretary of HHS to impose an "appropriate administrative penalty commensurate with the offense or conspiracy".

The ACA also obligates any person, other than a beneficiary, who has received an overpayment from a federal health care program to report and return the payment to the Secretary of HHS, the state, or to the appropriate carrier or contractor. The overpayment must be returned by the later of 60 days after the overpayment is identified or the date any corresponding cost report is due.

About the TCORS Medicaid Group

Our Medicaid Audit Department is comprised of Attorney Robert D. Tobin, partner; Attorney Joseph J. Selinger, partner; James Wietrak, former DSS Director of Quality Assurance; and Denise Smith, Certified Professional Coder and Medical Auditor. They are prepared to conduct Medicaid compliance reviews or "mock audits" of a number of Medicaid providers to identify areas of potential weakness and recommended corrective actions. Both Jim and Denise have extensive knowledge of the requirements governing various types of healthcare providers and continuously keep informed as to the ongoing audits and proposed rules affecting Connecticut's providers.

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  We replicate an actual Medicaid audit to determine your organization's compliance weaknesses that could save you from costly financial disallowances and extrapolated audit adjustments.

- **Assistance During the Audit Process**

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