
CHAPTER 13 – FRAUD AND ABUSE POLICIES AND PROCEDURES

The purpose of this chapter is to provide contractors and agents of Community Health Network of Connecticut, Inc. (CHNCT) with CHNCT's policies regarding fraud and abuse, the federal False Claims Act (established under sections 3729 through 3733 of Title 31, United States Code); administrative remedies for false claims and statements (the Program Fraud Civil Remedies Act of 1986 established under chapter 38 of title 31, United States Code); Connecticut state laws pertaining to civil or criminal penalties for false claims and statements involving federal healthcare programs, including Medicaid; and whistleblower protections under such laws, as required by the Deficit Reduction Act of 2005 (DRA).

POLICY STATEMENT ON FRAUD AND ABUSE

As a government contractor, CHNCT recognizes the importance of protecting the integrity of the programs it administers. CHNCT is committed to conducting all activities in accordance with high ethical standards and in compliance with all applicable laws and regulations.

- CHNCT does not tolerate any type of fraud or abuse, whether committed by a provider, member, employee or vendor.
- CHNCT is dedicated to aggressively detecting, investigating and preventing fraud and abuse in the government programs we administer.
- CHNCT fully cooperates with law enforcement and government agencies in their efforts to prosecute individuals or entities that commit fraud.
- CHNCT strives to educate our employees, members and providers on fraud and abuse and the negative effects it has on our economy. CHNCT encourages these individuals to report any concerns about fraud and abuse they have to us.
- CHNCT will ensure that all employees, including management, and any contractors or agents of CHNCT are educated regarding the federal and state false claims laws and the role of such laws in preventing and detecting fraud, waste and abuse in federal health care programs.

CHNCT'S COMPLIANCE AND ETHICS PROGRAM

CHNCT developed its Compliance and Ethics program in 2002. As part of this program, the Compliance and Government Affairs area is responsible for program integrity, which includes investigating reports of fraud and abuse. CHNCT's Program Integrity Analyst's responsibilities include, but are not limited to, the following:

- Performing health care fraud investigations, which include: reviewing, researching and documenting potential fraud and abuse activities through claims screening, system research, information gathering and policy reference;
- Identifying and investigating potential fraud from reports and referrals;
- Analyzing data through CHNCT's fraud detection software; and
- Conducting fraud awareness training.

With respect to Program Integrity, CHNCT's goals are to:

- Prevent, detect and investigate potential fraud and abuse committed by practitioners/ providers, members and/or employees;
- Implement internal policies and processes when appropriate to prevent future errors from occurring;
- Coordinate with the appropriate government agencies and/or law enforcement to report all instances of suspected fraud;
- Cooperate fully with all investigations of fraud conducted by government agencies and/or law enforcement;

- Recover payments lost to fraudulent and/or abusive billing;
- Educate staff on identifying fraud and abuse as it relates to CHNCT; and
- Provide effective methods for internal and external individuals to report suspected fraud or abuse to CHNCT.

REPORTING SUSPECTED FRAUD OR ABUSE

CHNCT offers a toll-free hotline to report suspected fraud and abuse. Individuals may call 1-866-700-6109 to report concerns. Please include as much information about the activity as possible.

LAWS CREATING PENALTIES FOR FALSE CLAIMS AND STATEMENTS IN THE MEDICAID PROGRAM

1. Federal False Claims Act, 31 U.S.C. § 3279: The federal False Claims Act is one of the Government's primary ways to fight fraud and abuse in government funded contracts or programs, including Medicaid. Under the False Claims Act, it is a violation for anyone (including entities such as businesses and managed care providers) to **knowingly**:

- Present or cause to be presented , a false claim for reimbursement by a Federal health care program, including Medicaid or Medicare;
- Make, use or cause to be made or used, a false record or statement material to a false or fraudulent claim;
- Repay less than what is owed to the Government;
- Make, use or cause to be made or used, a false record or statement material to reducing or avoiding repayment to the Government; and/or
- Conspire to defraud the Federal Government through one of the actions listed above.

CLAIMS

- The False Claims Act is not limited to false health care claims but also includes any false statements or records that are material to the claim.
- In addition, the government has prosecuted health plans that fail to comply with applicable Medicaid statutes and regulations that are a condition or a requirement of payment.
- For Medicaid managed care plans like CHNCT, fraud can occur in the areas of contract procurement (e.g., falsifications), marketing (e.g., misleading potential members), enrollment and disenrollment (e.g., cherry picking enrollees), underutilization (delaying or discouraging care), and data collection and submission (e.g., misclassifying enrollees).

LIABILITY

- A health plan or anyone that violates the False Claims Act can be subject to civil monetary penalties ranging from \$5,500 to \$11,000 for each false claim submitted.
- In addition to this civil penalty, a health plan or anyone who has violated the False Claims Act can be required to pay three times the amount of damages sustained by the U.S. government.
- If a health care organization is convicted of a False Claims Act violation, the OIG may seek to exclude the health care organization from participation in federal health care programs.

EXAMPLES OF ACTS THAT WOULD VIOLATE THE FALSE CLAIMS ACT INCLUDE, BUT ARE NOT LIMITED TO:

- Filing a claim for services that were not rendered;
- Double billing for items or services;
- Prescribing unnecessary medications or drugs;
- Failing to provide correct data on hospital cost reports to the Government;

- Falsifying medical records to maximize payments;
- Falsely certifying as to medical necessity;
- Filing a claim for a more expensive service than the one actually provided (upcoding);
- A contractor falsifying information regarding the cost of products/ services it sells to the Government; and/or
- Knowingly making false statements or falsifying records that would cause a claim to be submitted.

2. Program Fraud Civil Remedies Act of 1986, 31 U.S.C. § 3801: The Program Fraud Civil Remedies Act (herein referred to as “Act”) of 1986 is a law similar to the federal False Claims Act. It provides additional penalties separate from the False Claims Act for improper claims and improper statements.

IMPROPER CLAIMS

- A person violates the Act if they know or have reason to know they are submitting a claim that is:
 - False, fictitious or fraudulent; or
 - Includes or is supported by written statements that are false, fictitious or fraudulent; or
 - Includes or is supported by a written statement that omits a material fact; the statement is false, fictitious or fraudulent as a result of the omission; and the person submitting the statement has a duty to included the omitted facts; or
 - For payment for property or services not provided as claimed.
- A violation of this provision of the Act carries a penalty of \$5,000 for each such improper claim. In addition, an assessment of two times the amount of the claim may be made, unless the claim has not actually been paid.

IMPROPER STATEMENTS

- A person violates the Act if they submit a written statement which they know or should know:
 - Asserts a material fact which is false, fictitious or fraudulent; or
 - Omits a material fact and is false, fictitious or fraudulent as a result of the omission. In this situation there must be a duty to include the fact and the statement submitted contains a certification of the accuracy or truthfulness of the statement.
- A violation of the provision for submitting an improper statement carries a civil penalty of up to \$5,000.

Connecticut Laws and Regulations Pertaining to Fraud and Abuse: In addition to the federal false claims provisions, Connecticut laws also contain provisions pertaining to false statements and fraud and abuse in connection with the submission of health care claims.

1. Vendor Fraud, Connecticut General Statutes (CGS). §53a-290 – 53a-296, CGS §17b-99 and CGS §17b-25a: Under Connecticut law, a person commits “vendor fraud” when the person, acting individually or on behalf of an entity, and acting with the intent to defraud, provides goods or services to a beneficiary of one of several DSS programs (including Medicaid, Charter Oak and SAGA) and does any of the following:

- Presents a false claim for payment;
- Accepts payment for goods or services performed that exceeds the amount due;
- Solicits a beneficiary for the purpose of performing services or selling them goods that the beneficiary is not in need of;
- Sells goods to or performs services for a beneficiary without prior authorization from DSS when prior authorization is required; or
- Accepts additional compensation from any other person than the state that is in excess of the amount authorized by law.

A person guilty of vendor fraud is subject to criminal penalties that vary depending on the value of the goods or services fraudulently provided. A “vendor” for purposes of this statute includes all providers and suppliers of goods and services for which a claim would be submitted under the applicable DSS program.

In addition to criminal penalties, individuals or entities found guilty of vendor fraud are also subject to administrative penalties by the State, which include, but are not limited to:

- Forfeiture, suspension or revocation of any license held from the state;
- Termination from participation in any federal or state funded program, such as Medicare, Medicaid, Charter Oak and SAGA; and/or
- Recovery by the State of any money paid as a result of vendor fraud.

Under CGS §1 7b-25a, the Commissioner of DSS is required to provide a toll-free telephone line for individuals to report vendor fraud in any program operated by DSS. Reports of vendor fraud can be made to DSS at 1-800-842-2155.

2. Prohibition on Reimbursement of Sanctioned Individuals, CGS §17b-99(a). Vendors are not eligible to receive reimbursement for any goods or services provided by a person who is convicted of a crime involving fraud in federal or state funded programs. Vendors are required to notify DSS within 30 days after the date of employment or conviction of certain information related to the extent of services performed by a person convicted of a crime involving fraud in Medicare, Medicaid, Charter Oak, SAGA or other state or federal funded assistance programs. Vendors are also required to notify DSS of the identity of any person convicted of a crime involving fraud in such programs that has ownership or control interest in the vendor or is an agent or an employee of the vendor.

3. DSS Authority to Impose Administrative Sanctions Against Vendors and/or Providers of Goods and Services under Medicaid Program, Regulations of Connecticut State Agencies, §§1 7-83k-1 – 17-83k-7: These regulations describe policies and procedures for administrative sanctions to be imposed against vendors and providers of goods and services provided to beneficiaries of certain federal and state programs, including Medicare, Medicaid, Charter Oak and SAGA.

- Violations that may trigger administrative sanctions include:
 - False statements or representations knowingly and willfully made or caused to be made for the purpose of claiming or determining payment;
 - Services furnished or ordered in excess of the recipient’s need;
 - Failure to adhere to the conditions of vendor/provider participation in the program;
 - Accepting payment in excess of the amount authorized by law;
 - Submitting requests for payment containing charges or costs in excess of customary charges or costs; and
 - Any fraudulent acts and/or false reporting proscribed by federal or state statutes.
- Sanctions may include, but are not limited to, any one or more of the following:
 - An order to make restitution with interest;
 - Suspension from participation; and/or
 - Limitation on a provider’s participation.
 - Notice of DSS’ decision shall be given to any applicable professional society and licensing agency.

- Vendors that have been convicted in any state or federal court of a crime involving fraud in any of these programs shall be terminated from participation in such programs.

4. Health Insurance Fraud Act, CGS. §§53-440 – 53-445: Connecticut’s criminal statutes include provisions for health insurance fraud. A person or entity is guilty of health insurance fraud when that person or entity, with the intent to defraud or deceive any insurer:

- Makes oral or written statements that are false, incomplete, deceptive or misleading (or omits material information) in connection with an application for insurance or a claim for payment under a plan providing health care benefits, or
- Assists, solicits or conspires with another to prepare or present false or misleading written or oral statements in support of an insurance application or claim for payment.
- “Misleading information” under this statute includes, but is not limited to, falsely representing that goods or services were medically necessary in accordance with professionally accepted standards.

A person or entity found guilty of health insurance fraud may be subject to penalties of up to \$15,000 for each separate offense and/or imprisonment. In addition to any fines or term of imprisonment, such person or entity would also be required to pay back the insurer, including reasonable attorneys’ fees and investigation costs. This law also protects individuals who file reports of suspected health insurance fraud in good faith to the Insurance Commissioner from liability for libel, slander or any other civil liability in connection with this filing or furnishing of information.

Other Connecticut Criminal Statutes: Other Connecticut criminal statutes may become implicated in any type of fraud or abuse committed in connection with health care programs. These include:

- Tampering with or Fabricating Physical Evidence, CGS §53a-155: A person is guilty of tampering with or fabricating physical evidence, if the person is aware that an official proceeding is pending or about to begin, and that person: (a) alters, destroys conceals or removes any record, document or thing meaning to impair its verity or availability in such proceeding; or (b) makes, presents, or uses any record, document or thing knowing it to be false and meaning to mislead a public servant who is or may be engaged in such official proceeding. Tampering with physical evidence is a class D felony.
- False Statement Intending to Mislead Public Servant, CGS §53a-157b: A person is guilty of a false statement in the second degree when he/she knowingly and intentionally makes a false written statement under oath or on a form with a notice that false statements made therein are punishable, with the intent to mislead a public servant in the performance of his official function. This offense is a class A misdemeanor.
- larceny, CGS §53a-118 et seq: A person commits larceny when, intending to deprive another of property or to appropriate such property, he/she wrongfully takes, obtains or withholds such property from an owner. Examples of larceny include embezzlement, obtaining property by false pretenses or misrepresentations, falsely authorizing, certifying or filing a claim for benefits from a governmental agency and accepting benefits from a claim known to be false. Larceny is classified as a range of felonies and misdemeanors depending upon the nature of the offense and the dollar amount involved.

LAWS RELATED TO THE REPORTING OF FALSE CLAIMS AND STATEMENTS IN THE MEDICAID PROGRAM

1. Qui Tam Whistleblower Provisions, 31 U.S.C. §3730(h): To encourage individuals to come forward and report misconduct involving false claims, the Federal False Claims Act includes a “qui tam” or whistleblower provision. This provision essentially allows any person with actual knowledge of allegedly false claims to the government to file a lawsuit on behalf of the U.S. government. Such persons are referred to as “relators.”

Qui Tam Procedure

- The whistleblower/ relator must file his or her lawsuit on behalf of the government in federal district court.
- The lawsuit will be filed “under seal,” meaning the lawsuit is kept confidential while the government reviews and investigates the allegations contained in the lawsuit and decides how to proceed.

Rights of Parties to Qui Tam Actions

- If the government determines the lawsuit has merit and decides to intervene, the prosecution of the lawsuit will be directed by the U.S. Department of Justice.
- If the government decides not to intervene, the whistleblower can continue with the lawsuit on his or her own.

Award to Qui Tam Whistleblowers

- If the lawsuit is successful, and provided certain legal requirements are met, the relator or whistleblower may receive an award ranging from 15 to 30 percent of the amount recovered. The whistleblower may also be entitled to reasonable expenses including attorneys’ fees and costs for bringing the lawsuit.
- If, however, the whistleblower is convicted of criminal conduct related to his or her role in the preparation or submission of the false claims, the whistleblower will be dismissed from the civil action and will not receive any portion of the funds recovered.

Whistleblower Rights

- The False Claims Act prohibits employers from retaliating against employees, contractors or agents who file or participate in the prosecution of a whistleblower suit.
- Employees, contractors or agents who are discharged, demoted, suspended, threatened, harassed or in any way discriminated against in the terms and conditions of employment by their employer for “blowing the whistle” are entitled to recover all relief necessary to make the employee, contractor or agent whole.
- Damages available to the employer, contractor or agent who proves retaliation include: reinstatement with the same seniority status; two times back pay; interest on back pay; compensation for special damages (i.e., emotional distress); and litigation costs and attorneys fees.

2. Connecticut Laws Pertaining to Whistleblowing: Connecticut law also has provisions to encourage reports of fraud or abuse in government-funded programs and contracts and to protect individuals who make such reports. These laws include the following:

- Whistleblowing, CGS §4-61dd and Regulations of Connecticut State Agencies §§4-61dd-1 et seq.:
 - Anyone with knowledge of corruption, fraud, abuse, gross waste of funds, unethical practices or violation of state laws or regulations occurring in any state department or agency or under any large state contract may report such information to the Auditors of Public Accounts for further review and inquiry.
 - State and state agency officers and employees, and officers/employees of a large state contractor are prohibited from threatening or taking any personnel action against an employee of a state agency or contractor in retaliation for making report of information under the above provision, under mandated reporting statutes, or to the appropriate state agency (i.e. DSS) concerning information involving a large state contract. Violation of this provision may result in inquiry by the Attorney General’s office and the imposition of civil penalties against the agency or large state contractor.
 - An employee against whom personnel action violating (2) above has been threatened or taken may make a complaint to commence a hearing before the Chief Human Rights Referee in accordance with the procedures set forth in

Connecticut Regulations §§4-61dd-1 et seq, or may alternatively bring a civil action, for reinstatement, back pay and other damages and costs to the employee.

- State agencies and large state contractors are prohibited from threatening to impede, canceling or not renewing a contract with a subcontractor in retaliation for the disclosure of information under (1) above and may be subject to civil action for damages and costs for such an action.
- All reports of information must be in good faith. Employees may be subject to discipline and dismissal for malicious and false reports.
- Protection of Employees for Disclosure of Employer Conduct, CGS §31-51m and §31-51q: Under Connecticut labor laws, employers are prohibited from discharging, disciplining or otherwise penalizing any employee because the employee in good faith:
 - Reports a violation or suspected violation of local, state or federal laws or regulations to a public body;
 - Participates in an investigation, hearing, inquiry or court action upon the request of a public body, or
 - Exercises certain of the employee's constitutional rights in a manner that does not interfere with the employee's job performance.

Employers may be subject to a civil action for damages and costs for violation of such prohibitions

3. Regulations Providing a Financial Incentive for Reporting Vendor Fraud, Regulations of Connecticut State Agencies, §§17b-102-01 – 17b-102-04 and CGS §17b-102: Connecticut law permits the Commissioner of DSS to provide a financial incentive to report vendor fraud in any DSS program through offering a person up to fifteen percent (15%) of any amount recovered by DSS as a result of the person's report; the award is subject to the following conditions and limitations defined by state regulations:

- The Commissioner of DSS shall determine whether or not a person is entitled to a financial incentive and if so, what the amount of the financial incentive will be.
- Payment shall not exceed 15% of the amounts recovered by the State that are directly attributed to the person's report.
- A financial incentive is authorized when the person reporting has not participated in or benefited from the fraudulent activity being reported, there is a direct correlation between the information reported and amounts recovered by the State and the person reporting submits a claim for the financial incentive in the form and manner directed by DSS.
- A financial incentive is not authorized if the person reporting requests to remain anonymous, DSS or another state or federal agency has initiated an audit, investigation or similar proceeding prior to the person's report of fraud, or the person reporting (or a member of his/her immediate family) is employed in a job that involves auditing, investigation or enforcement involving DSS programs.