June 30, 2023

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

- Nuvance Health'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; and
- Laws of the State of Connecticut and the State of New York (hereinafter collectively referred to as "State") pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under these laws, as such laws relate to fraud prevention in Federal healthcare programs.

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 responsibilities, duties, and role in a manner that is both legally compliant and in adherence with the professional and ethical standards outlined in Nuvance Health's 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, Nuvance Health's Corporate Compliance Office has prepared, in memorandum form, a summary of these laws and relevant policies and procedures. The memorandum is available to Covered Individuals on Nuvance Health's *The Hub* and external web pages as follows:

- **Nuvance Health *The Hub*:**
  - **Nuvance Health East**
  - **Nuvance Health West**

- **Nuvance Health External Webpage:**

  - Nuvance Health

Nuvance Health is providing this information on its own behalf and on behalf of its affiliates Danbury Hospital (which includes its New Milford Hospital campus), Northern Dutchess Hospital, Norwalk Hospital, Putnam Hospital Center, Sharon Hospital, Vassar Brothers Medical Center, Nuvance Health Medical Practice, P.C., Nuvance Health Medical Practice CT, Inc., Health Quest Urgent Care, Health Quest Home Care, Western Connecticut Home Care, WCHN Affiliates, Health Quest Affiliates, and the Heart Center.

Lastly, it is important to underscore that Covered Individuals may contact Nuvance Health's Confidential Compliance and Ethics Helpline (the "Helpline") at **1-844-395-9331** (for Nuvance Health East) and **1-844-YES-WECOMPLY** (for Nuvance Health West) to report any compliance issue, concern, or incident of which they may be aware.

Remember, ***Ask Questions. Voice Your Concerns. Report Improper Conduct***. Note that, Covered Individuals may submit a compliance report through the Helpline anonymously. Further, Nuvance Health strictly enforces its non-retaliation policies and takes every effort to protect whistleblowers from retribution, intimidation, harassment, 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 Nuvance Health in satisfying its obligations under the DRA and meeting its compliance goals. We encourage you to view the numerous Program-related policies in their full length on the Nuvance Health intranet and external webpages at the links provided above.

We greatly appreciate your continued and ongoing support of the Program.

Wayne A. McNulty, JD, ALM, MS, CFE, CIPP, CHC
Chief Compliance, Audit & Privacy Officer

Corporate Compliance Office
100 Reserve Road
Danbury, CT 06810

O (203) 739 7110
F (203) 739 1680

nuvancehealth.org

MEMORANDUM

To: All Nuvance Health Workforce Members
All Nuvance Health Business Affiliates
All Nuvance Health Agents

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

Date: June 30, 2023

Re: **Deficit Reduction Act of 2005**

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

Accordingly, the paragraphs that follow, along with the accompanying attachment, provide a synopsis of: (i) pertinent provisions of the DRA; (ii) Nuvance Health's policies and procedures that address fraud, waste, and abuse; and (iii) the various United States Federal ("Federal") and State of Connecticut and State of New York (collectively referred to as "State") laws that prohibit the submission of false claims and statements and provide whistleblower protections.

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*

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[1] For purposes of this memorandum, the term Covered Individuals shall mean all Nuvance Health: (i) workforce members (*e.g.*, employees, affiliates, personnel, medical staff members, governing body members, officers, administrators, managers, trainees, volunteers, students, appointees, and individuals whose conduct is under the direct control of Nuvance Health or one of its affiliates, whether or not they are paid by Nuvance Health); (ii) business affiliates (*e.g.*, all non-workforce member contractors, subcontractors, independent contractors, vendors or other third parties who, in acting on behalf of Nuvance Health: (a) deliver, furnish, prescribe, direct, order, administer, authorize or otherwise provide Federal healthcare program items and services or contribute to Nuvance Health's entitlement to payment under Federal healthcare programs; (b) perform billing or coding functions; (c) are involved in the monitoring of healthcare provided by Nuvance Health; or (d) are affected by the Nuvance Health's compliance program policies or applicable risk areas (*see* footnote 18, *infra*, and **Appendix** "B")); and (iii) agents (*e.g.*, individuals or entities who have entered into an agency relationship with Nuvance Health). *See* CMS DRA 6032 – 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 6/28/23).

[2] *See* 42 U.S.C. § 1396-a [a][68]; *see also* Social Services Law § 363-d [2][a][8]; 18 NYCRR § 521-1.4 [a][2][ix].

Recovery Employee Education provisions of the DRA, as well as the corresponding implementing provisions of New York State Social Services Law, Nuvance Health is required, as a condition of its participation in Medicaid, to establish written policies and procedures that inform Covered Individuals about the following regarding the prevention and detection of fraud, waste, and abuse in Federal healthcare programs:[3]

- Nuvance Health'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;
- Federal and State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under these laws, as such laws relate to fraud, waste, and abuse prevention in Federal healthcare programs.

An overview of the Nuvance Health Compliance and Ethics Program ("Program") is provided in § II below. Additionally, pertinent Nuvance Health policies and procedures designed to detect and prevent fraud, waste and abuse are summarized in the table found in § III. Lastly, with regard to the prevention and detection of fraud, waste and abuse in Federal healthcare programs, **Appendix** "**A**" provides a detailed outline of: (i) the Federal and State False Claims Acts; (ii) Federal administrative remedies for false claims and statements; and (iii) Federal and State laws governing the imposition of civil and criminal penalties for false claims and statements and corresponding whistleblower protection laws.

II. ADOPTION OF RECOGNIZED COMPLIANCE AND ETHICS PROGRAM PRINCIPLES

Nuvance Health is committed to compliance with applicable legal requirements and sound ethical standards and satisfying the requirements described for an effective compliance program under the 2021 United States Sentencing Commission Guidelines § 8B2.1 - *Effective Compliance and Ethics Program*.[4]

Additionally, in establishing an effective compliance program, Nuvance Health refers to Federal and State advisory materials for guidance, including but not limited to: (i) 1998 and 2005 OIG *Compliance Program Guidance for Hospitals* and *Supplemental Compliance Program Guidance for Hospitals*, respectively;[5] (ii) 2000 OIG *Compliance Program for Small and Individual Group Practices*;[6] (iii) 2000 and 2008 OIG *Compliance Program Guidance for Nursing Facilities* and *Supplemental Compliance Program Guidance for Nursing Facilities*, respectively;[7] (iv) 1998 OIG *Compliance Program Guidance for Home Health Agencies*;[8] (v) 2005 OIG Draft Compliance

[3] *See* 42 U.S.C. § 1396-a [a][68]; *see also* New York Social Services Law § 363-d [2][a][8]. Federal healthcare programs include Medicare, Medicaid, and TRICARE.
[4] *See* 2018 United States Sentencing Commission Guidelines Manual § 8B2.1.
[5] *See* 63 Fed. Reg. 8987 (1998); 70 Fed. Reg. 4858 (2005).
[6] *See* 65 Fed. Reg. 59434 (2000).
[7] *See* 65 Fed. Reg. 14289 (2000); 73 Fed. Reg. 56832 (2008).
[8] *See* 63 Fed. Reg. 42410 (1998).
[9] 70 Fed. Reg. 71312 (2005)

Program Guidance for Recipients of PHS Research Funds;[9] (vi) United States Department of Justice, *Evaluation of Corporate Compliance Programs Guidance Document* (March 2023 Update);[10] and (vii) New York State Office of the Medicaid Inspector General ("OMIG"), *New York State Social Services Law 363-d and Title 18 New York Codes Rules and Regulations Part 521 Compliance Program Review Guidance* (2016), as well as the OMIG's *Compliance Program Guidance* (January 2023), *Compliance Program Review Module* (March 2023), and *Compliance Program Self-Assessment Form* (June 2023).[11]

Nuvance Health consists of numerous entities that are enrolled providers in the New York State Medical Assistance Program and, as such, complies with the requirements for provider compliance programs set forth under Social Services Law § 363-d and its implementing *Fraud, Waste and Abuse Prevention Program* regulations found at 18 NYCRR Part 521 (collectively hereinafter referred to as "Part 521").

To meet the requirements for an effective compliance program as described in the guidance documents listed above, the USSC Guidelines Manual, and Part 521, Nuvance Health's Program must, at the minimum, be comprised of the following seven (7) key elements:

- ***ELEMENT # 1***[12] The development and dissemination of written policies and procedures including, without limitation: (i) standards of conduct (*e.g.*, code of ethics, code of conduct), that promote Nuvance Health's commitment to conduct its operations in a legally compliant and ethical manner; and (ii) policies and procedures that:

  - implement the operation of the Program;
  - Apply to all Covered Individuals and must identify Federal and State laws that apply to Nuvance Health's risks areas
  - provide guidance to Covered Individuals regarding compliance issues and concerns;
  - identify communication methods available for Covered Individuals to seek compliance guidance or make compliance reports;
  - outline how compliance issues, concerns, and violations are investigated and resolved;
  - require Covered Individuals to refuse to participate in unethical and illegal conduct and to report unethical or illegal conduct that they are aware of to the CCO; and

[10] United States Department of Justice, Criminal Division, *Evaluation of Corporate Compliance Programs Guidance Document* (Updated March 2023), available at: https://www.justice.gov/criminal-fraud/page/file/937501/download (last accessed on 6/30/23). Note, Nuvance Health also refers to the U.S. Department of Justice *September 15, 2022 Deputy Attorney General Monaco Memorandum* for guidance (*see* Monaco, Lisa, U.S. Department of Justice, *Memorandum - Further Revisions to Corporate Criminal Enforcement Policies Following Discussions with Corporate Crime Advisory Group* (9/15/22)(available at: https://www.justice.gov/opa/speech/file/1535301/download) (last accessed on 9/28/22).

[11] *See* New York State Office of the Medicaid Inspector General, *New York State Social Services Law 363-d and Title 18 New York Codes of Rules and Regulations Part 521 Compliance Program Review Guidance* (2016); *see also* OMIG Compliance Library (available at: https://omig.ny.gov/compliance/compliance-library)(last accessed on 6/30/23).

[12] *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], 8995 § II [E][1] (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"*] & 59444 [II][B]["*Step 7*"];, (2000); N.Y. SOC. SERV. § 363-d[2][a] & [2][h]; 18 NYCRR §§ 521-1.4 [a][2][i], [a][2][iv][b], [a][2][vii].

- set forth Nuvance Health whistleblower protection/antiretaliation policies.

- ***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: (i) provide advice, counsel, assistance, and other support to the CCO; and (ii) coordinate Program implementation activities.[13]

- ***ELEMENT # 3*** – The development of training and education for all affected Covered Individuals, which shall: (i) be made part of any new workforce member orientation; (ii) occur on least an annual basis; (iii) include the development and maintenance of a training plan; and (iv) cover Nuvance Health's compliance risk areas.[14]

- ***ELEMENT # 4*** – The establishment and implementation of open, accessible, published, and effective lines of communication between the CCO and all Covered Individuals. Additionally, the maintenance of a process, such as a publicized confidential compliance helpline, to receive concerns, reports, requests for guidance, complaints, and other compliance-related issues in an anonymous and confidential manner directly to the CCO.[15]

- ***ELEMENT # 5*** – The establishment and fair and consistent enforcement of written disciplinary standards, policies, and procedures for Covered Individuals who have failed to comply with applicable Federal and State law, Federal healthcare program requirements, and Nuvance Health's internal standards of conduct (or who have otherwise engaged in prohibited activities) and encourage good faith participation in the compliance program by Covered Individuals.[16]

- ***ELEMENT # 6*** - The performance of auditing and monitoring to facilitate the ongoing and routine monitoring of the Program and to identify compliance-related risks. This includes, but is not limited to:[17]

  - The performance of internal and external audits focused on compliance program risk areas outlined in OMIG Fraud, Waste, and Abuse Prevention program regulations including, without limitation, risk identified by organizational experience;

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[13] *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; N.Y. SOC. SERV. § 363-d[2][b]; 18 NYCRR § 521-1.4 [c].

[14] *See* 63 Fed. Reg. 8987, 8989 § II & 8994 § II [C]; 65 Fed. Reg. § 59434, 59436, [II][A] & 59442-59443, [II][B]["*Step 4*"]; N.Y. SOC. SERV. § 363-d[2][c]; 18 NYCRR § 521-1.4 [d][2], [d][1][i] & [d][4].

[15] *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*"]; N.Y. SOC. SERV. § 363-d[2][d]; 18 NYCRR § 521-1.4 [e][1-3]; N.Y. Soc. Serv. Law 363-d [2][d].

[16] *See* 18 NYCRR § 521-1.4 [f] & N.Y. SOC. SERV. § 363-d[2][e]; *see also* 63 Fed. Reg. 8987, 8989 § II & 8995 § II [E][1-2]; 65 Fed. Reg. § 59434, 59436, [II][A] & 59444 [II][B]["*Step 7*"]..

[17] *See* N.Y. SOC. SERV. § 363-d[2][f]; 18 NYCRR § 521-1.4 [g][1][i], [g][3], [g][2]; *see also* 63 Fed. Reg. 8987, 8989 § II & 8996 § II [F][1-2]; 65 Fed. Reg. § 59434, 59436, [II][A] & 59437-59438, [II][B]["*Step 1*"].

- The performance of exclusion/ineligible persons checks every 30 days; and
- The performance of an annual Program review to determine:

  - ✓ Compliance with Federal and State law, Federal healthcare program requirements, and 18 NYCRR Part 521;
  - ✓ Program effectiveness; and
  - ✓ Whether any part of the Program requires revision or corrective action

- ***ELEMENT # 7 –*** Responding to Compliance Issues, which includes the establishment of processes, policies, and procedures concerning the prompt responding to compliance issues once raised and received or learned through internal auditing and monitoring. This includes 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 timely refunding of any overpayments.[18]

III. NUVANCE HEALTH COMPLIANCE POLICIES AND PROCEDURES

Nuvance Health has written policies and procedures for all Covered Individuals that provide detailed information about the following laws and regulations related to Federal healthcare programs: (i) the Federal False Claims Act, including remedies for false claims and statements; (ii) State laws pertaining to civil or criminal penalties for false claims and statements and whistleblower protections under such laws; and (iii) the prevention and detection of fraud, waste and abuse in Federal and State health care programs. The table below provides a brief summary of these policies for your review:

Category	Nuvance Health East	Nuvance Health West
Compliance and Ethics Program Charter	***Applies across the Nuvance Health System.*** The purpose of the Nuvance Health ***Compliance and Ethics Program Charter*** is to establish an organizational culture throughout Nuvance Health that promotes prevention, detection, and resolution of conduct that fails to comply with: applicable Federal and State administrative, civil, and criminal law; the requirements of Federal healthcare programs and private payors; and Nuvance Health's standards of ethical and business conduct and the implementing policies and procedure thereof.	

[18] *See* 18 NYCRR § 521-1.4 [h]; N.Y. SOCIAL SERVICES LAW § 363-D [6], [7]; *see also* 63 Fed. Reg. 8987, 8989 § II & 8997-8 § II [G][1-2]; 65 Fed. Reg. § 59434, 59436, [II][A] & 59443 [II][B]["*Step 5*"]. Note, under New York State's *Fraud, Waste, and Abuse Prevention Program* regulations found at 18 NYCRR Part 521, compliance programs, including Nuvance Health's Compliance and Ethics Program, must at the minimum apply to the following nine (9) risk areas: (i) billings; (ii) payments; (iii) ordered services; (iv) medical necessity; (v) quality of care; (vi) governance; (vii) mandatory reporting; (viii) credentialing; (ix) contractor, subcontractor, agent or independent contract oversight; and (x)other risk areas that are or should be reasonably identified by the provider through its organizational experience. (*See* 18 NYCRR § 521-1.3 [d]). Pursuant to 10 NYCRR § 521-1.4 [a][2][i], **Appendix** "B" (annexed hereto) identifies the governing laws, regulations, and New York Medicaid policies and procedures applicable to these risk areas.

Category	Nuvance Health East	Nuvance Health West
Corporate Compliance Program Manual	***Applies across the Nuvance Health System.*** The ***Corporate Compliance Program Manual*** describes and defines the Compliance Program with the purpose of promoting the highest ethical standards and conducting business in compliance with all Federal and state health care program rules, regulations	
Corporate Compliance Program Policies	The ***Corporate Compliance Program Policy*** describes the key components of the Corporate Compliance and Ethics Program and seeks to ensure full compliance with all applicable Federal and State laws, rules, and regulations and the highest standards of ethical conduct.	***The Compliance Disclosure Program Policy & Procedure*** establishes methods to report potential compliance issues or concerns including violations of: (i) internal policies; (ii) Federal and State law; and Federal healthcare program requirements.
Whistleblower Protection Policy	***Applies across the Nuvance Health System.*** The purpose of the ***Whistleblower Protection Policy*** is to: (i) facilitate, without fear of retribution, the good faith disclosure and reporting by Protected Persons of improper or illegal conduct or other activities, which they have become aware of; and (ii) communicate Nuvance Health's strict prohibition against the engagement of retaliatory conduct by Covered Individuals.	
Fraud, Waste, and Abuse Policies	The ***Prevention of Fraud, Waste, and Abuse Policy*** provides a brief outline of the Federal False Claims Act and mandates all employees, contractors, and agents 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.	The ***Detection and Prevention of Fraud, Waste and Abuse Policy (Pursuant to the Federal Deficit Reduction Act of 2005)*** **p**rovides detailed information concerning (i) the Federal False Claims Act; (ii) Federal laws and penalties pertaining to reporting and returning overpayments; (iii) State laws and penalties pertaining to false claims; and (iv) whistleblower protections under State law. The related procedure mandates that all workforce members raise any and all fraud, waste, and abuse concerns in accordance with the ***Compliance Disclosure Program Policy***.
Mandatory Reporting Policies	The ***Reporting of Compliance Questions or Concerns and Organizational Response Policy*** requires all employees and other interested individuals to report instances of suspected or perceived non-compliance.	The ***Compliance Disclosure Program Policy*** and ***Reportable Events Policy*** establish a mechanism for the good faith reporting of issues and concerns such as violations of: (i) the *Code of Conduct* and *Vendor Code of Conduct;* (ii) compliance program policies and/or applicable Federal and State healthcare program requirements. These policies also require workforce members to promptly report, in good faith, any suspected or actual violation as described above.

Category	Nuvance Health East	Nuvance Health West
Internal Investigation Policy	The ***Compliance – Internal Investigation Policy*** establishes the process 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 ***Corporate Compliance Program Manual*** (Element VII) establishes an investigatory process for the prompt response and investigation into potential offenses brought to the attention of the Compliance Office.

Please be advised that copies of the policies mentioned above, as well as other compliance-related policies, are available on Nuvance Health's *The HUB* intranet page and external websites as follows:

- **Nuvance Health East**
  - **The HUB**
  - **External**
- **Nuvance Health West**
  - **The HUB**
  - **External**

IV. The Nuvance Health Compliance and Ethics Helpline

To facilitate open communication of compliance-related questions, issues or concerns, Nuvance Health has established the following toll-free Confidential and Anonymous Compliance and Ethics Helplines that are available to all Covered Individuals:

- **1-844-395-9331** (Covered Individuals at Nuvance Health East)**;** or
- **1-844-YES-WeComply** (Covered Individuals at Nuvance Health West).

Nuvance Health requires all Covered Individuals to immediately report all forms of prohibited conduct including, without limitation, any activity or conduct that is contrary to or otherwise interferes with their responsibility to fulfill their day-to-day Nuvance Health work functions, duties, and role in an ethical and legally compliant manner. Examples of prohibited conduct that must be reported include the following:

- Conduct that constitutes fraud, waste, and abuse or violations of Federal Healthcare program requirements;
- Improper coding, billing or accounting;

- Improper patient referrals;
- Inappropriate access, use, disclosure, or disposition of confidential patient, workforce member or business information;
- Violation of HIPAA, information technology or record management policies and procedures;
- Organizational fraud such as corruption, misappropriation of corporate assets, bribery, the reporting of false or misleading financial statements, and the falsification of business records;
- Patient harassment, discrimination, abuse or other patient rights violations;
- The provision of substandard, unsafe or medically unnecessary patient care;
- Violations of Nuvance Health's *Human Subject Research Protection Program* policies and procedures;
- Workforce member harassment including, without limitation, sexual harassment and workforce member discrimination;
- Workplace incivility or conduct that amounts to a hostile work environment; and
- Engagement in retaliatory conduct.

V. CLOSING

Nuvance Health 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 conduct their functions, duties, and roles in a legally compliant and ethically conscious manner, Nuvance Health 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"

NUVANCE HEALTH

CORPORATE COMPLIANCE OFFICE

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

Federal and State Laws related to filing False Claims;
Administrative Remedies for False Claims and Statements; and
Federal and State Laws pertaining to Civil or Criminal Penalties for False Claims and Statements and Whistleblower Protection under Such Laws

[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 Nuvance Health Corporate Compliance Office for any questions regarding the content contained herein.

September 29, 2022

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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

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[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. (Dec. 2014)
[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 6/30/23).
[5] Health Care Compliance Association ("HCCA") Healthcare Professionals Manual, 23,303 ¶ 20,364. (Dec. 2014)
[6] *See* Health Care Compliance Association ("HCCA") Healthcare Professionals Manual, 23,320 ¶ 20,378. (Dec. 2014)

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 [$13,508] per claim filed. And under the civil FCA, each instance of an item or service billed to Medicare or Medicaid counts as a claim…." [13]

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[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 6/30/23) (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 6/30/23).

[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 (last accessed on 6/30/23)

[10] *See id.*

[11] *See* OIG Roadmap for New Physicians.

[12] CMS FCA description *citing* 31 U.S.C. § 3729 [b].

[13] *See* OIG Roadmap for New Physicians. Note, the penalty was updated in 2023 to $13,508 for Inflation Adjustment purposes (*see* Civil Monetary Penalties Inflation Adjustments for 2023, 88 FR 5776 (1/30/23) (available at:

Specifically, FCA penalties will be assessed not less than $13,508 and no more than $27,018 per claim filed.[14]

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."[15]

Examples of Potential False Claims Violations

The following are examples provided by CMS of potential FCA violations.[16] 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."[17]

Additionally, providers or suppliers are required to report and return an overpayment to the "Secretary, the state, an intermediary, a carrier or a contractor…by the later of 60 days after the overpayment was identified or the date the corresponding cost report was due and to notify the Secretary, the State or the intermediary, a carrier, or a contractor in writing for the reason for the overpayment."[18] Failure to do so will result in a false claim and liability under the FCA.[19]

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."[20] If successful, a *qui tam* relator (or

https://www.federalregister.gov/documents/2023/01/30/2023-01704/civil-monetary-penalties-inflation-adjustments-for-2023) (last accessed on 6/30/23)

[14] *See* Department of Justice, *Civil Monetary Penalties Inflation Adjustment*, 88 FR 5776 (1/30/23) (available at: https://www.federalregister.gov/documents/2023/01/30/2023-01704/civil-monetary-penalties-inflation-adjustments-for-2023) (last accessed on 6/30/23)

[15] *See* OIG Roadmap for New Physicians.

[16] CMS FCA description at p. 1.

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

[18] See 81. Fed. Reg. 7654 (2016).

[19] *Id*.

[20] 31 U.S.C. § 3730 [b].

"whistleblower") may share in a percentage of the proceeds from an FCA action or settlement.[21]

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 substantially contributed to the prosecution of the action.[22] 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.[23]

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

[21] *Id.*
[22] 31 U.S.C. § 3730 [d][1].
[23] 31 U.S.C. § 3730 [d][2].

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 [$13,508 and not more than $27,018],[24] as adjusted by the Federal 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—

[24] Note, the penalty was updated in 2023 to $13,508 for Inflation Adjustment purposes (*see* U.S. Department of Justice, Civil Monetary Penalties Inflation Adjustments for 2023, 88 FR 5776 (1/30/23) (available at: https://www.federalregister.gov/documents/2023/01/30/2023-01704/civil-monetary-penalties-inflation-adjustments-for-2023) (last accessed on 6/30/23)

(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 $13,508[25] for each claim. Additionally, the agency may recover twice the amount of the claim.[26] The determination of whether a claim is false, and the imposition of fines and penalties is made by the administrative agency.[27]

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…"[28]

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." [29] Such person shall be fined, or imprisoned a maximum of ten years, or both.[30]

F. Other federal health care laws related to the submission of false claims.[31]

Although not specifically required to be communicated under the DRA, the foregoing listing and description of statutes are important for workforce members, business affiliates, contractors, subcontractors, vendors and agents to know in order to assist Nuvance Health in its efforts in maintaining an effective compliance and ethics program, to understand their obligations under Nuvance Health'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.[32]

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[25] Note, the penalty was updated in 2023 to $13,508 for Inflation Adjustment purposes (*see* U.S. Department of Justice, Civil Monetary Penalties Inflation Adjustments for 2023, 88 FR 5776 (1/30/23) (available at: https://www.federalregister.gov/documents/2023/01/30/2023-01704/civil-monetary-penalties-inflation-adjustments-for-2023) (last accessed on 6/30/23)

[26] 31 U.S.C. § 3802 [a][1][D].

[27] 31 U.S.C. § 3803[a][1].

[28] 18 U.S.C. § 287.

[29] 18 U.S.C. § 286.

[30] 18 U.S.C. § 286.

[31] 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.

[32] 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 .

1) Anti-Kickback Statute (42 U.S.C. § 1320a-7b [b]).[33]

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[34] or the generation of business involving any item or service payable by the Federal health care programs.[35] 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, gifts and discounts, expensive hotel stays and meals, and excessive compensation for medical directorships or consultancies.[36]

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,[37] and exclusion from participation in the Federal health care programs.[38]

Note that physicians who pay or accept kickbacks also face penalties of up to $50,000 per occurrence[39] 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[40] and rental agreements,[41] investments in ambulatory surgical centers,[42] and payments to bona fide employees.[43] Additionally claims that result from an AKS violation are considered to be false claims under the FCA.

2) Physician Self-Referral Law, "Stark Law" (42 U.S.C. § 1395nn)[44]

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,

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[33] 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.
[34] 42 U.S.C. § 1320a-7b [b][1][A] & [2][A].
[35] 42 U.S.C. § 1320a-7b [b][1][B] & [2][B].
[36] *Id.*
[37] 42 U.S.C. § 1320a-7b [b][1] & [2].
[38] 42 U.S.C. § 1320a-7a [a][7].
[39] 42 U.S.C. § 1320a-7b[b]; *see also* OIG, "*A Roadmap for New Physicians; Fraud & Abuse Laws*", available at: https://oig.hhs.gov/compliance/physician-education/fraud-abuse-laws/ (last accessed 9/30/22)
[40] 42 C.F.R. § 1001.952 [d].
[41] 42 C.F.R. § 1001.952 [b].
[42] 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.*
[43] 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.
[44] 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.

unless an exception applies.[45] Financial relationships include both ownership/investment interests and compensation arrangements. For example, if a person were to invest in an imaging center, the Stark law requires the resulting financial relationship to fit within an exception or that person may not refer patients to the facility and the facility may not bill for the referred imaging services.[46]

Examples of "designated health services" include: clinical laboratory services;[47] Physical therapy, occupational therapy, and outpatient speech-language pathology services;[48] radiology and certain other imaging services;[49] radiation therapy services and supplies;[50] durable medical equipment and supplies;[51] parenteral and enteral nutrients, equipment and supplies;[52] prosthetics orthotics, and prosthetic devices and supplies;[53] home health services;[54] outpatient prescription drugs;[55] and inpatient and outpatient hospital services.[56]

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.[57] 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.[58] To be protected by an exception, an arrangement must satisfy all of the exception's requirements. Examples of exceptions include certain personal services[59] and rental agreements,[60] the academic medical center structure,[61] and payments to bona fide employees.[62]

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

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[45] *See* OIG, "*A Roadmap for New Physicians; Avoiding Medicare and Medicaid Fraud and Abuse*" *at* p. 6.
[46] *Id.*
[47] 42 C.F.R. § 411.351, "Designated Health Services" § [1][i].
[48] 42 C.F.R. § 411.351, "Designated Health Services" § [1][ii].
[49] 42 C.F.R. § 411.351, "Designated Health Services" § [1][iii].
[50] 42 C.F.R. § 411.351, "Designated Health Services" § [1][iv].
[51] 42 C.F.R. § 411.351, "Designated Health Services" § [1][v].
[52] 42 C.F.R. § 411.351, "Designated Health Services" § [1][vi].
[53] 42 C.F.R. § 411.351, "Designated Health Services" § [1][vii].
[54] 42 C.F.R. § 411.351, "Designated Health Services" § [1][viii].
[55] 42 C.F.R. § 411.351, "Designated Health Services" § [1][ix].
[56] 42 C.F.R. § 411.351, "Designated Health Services" § [1][x].
[57] 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/documents/provider-compliance-training/939/StarkandAKSChartHandout508.pdf (last accessed on 9/28/21).
[58] *Id.*
[59] 42 C.F.R. § 411.357 [d].
[60] 42 C.F.R. § 411.357 [a].
[61] 42 C.F.R. § 411.355 [e].
[62] 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/documents/provider-compliance-training/939/StarkandAKSChartHandout508.pdf (last accessed on 9/28/21).

health care benefit program."[63] 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.[64]

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),[65] a scheme "to defraud any health care benefit program;"[66] 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."[67]

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 both.[68] 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).[69]

5) Conspiracy to Commit Offense or to Defraud United States (18 U.S.C. § 371)

If two or more persons conspire either to commit any offense against the United States, or to defraud the United States, or any agency thereof in any manner or for any purpose, and one or more of such persons do any act to effect the object of the conspiracy, each shall be fined under this title or imprisoned not more than five years, or both.[70]

6) 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.[71]

7) 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;"[72] (ii) makes any statement or representation that is "materially false, fictitious, or fraudulent;"[73] or (iii) makes or uses any false writing or document knowing it to

[63] 18 U.S.C. § 669.
[64] 18 U.S.C. § 669.
[65] 18 U.S.C. § 1347 [b].
[66] 18 U.S.C. § 1347 [a][1].
[67] 18 U.S.C. § 1347 [a][1].
[68] 18 U.S.C. § 1347 [a][2].
[69] 18 U.S.C. § 1347 [a][2].
[70] 18 U.S.C. § 371.
[71] 18 U.S.C. § 1349.
[72] 18 U.S.C. § 1001 [a][1].
[73] 18 U.S.C. § 1001 [a][2].

contain any statement or entry that is "materially false, fictitious, or fraudulent statement or entry;"[74] shall be fined, imprisoned not more than 5 years, or both.[75]

8) False statements relating to health care matters (18 U.S.C. § 1035)[76]

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;"[77] (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,[78] 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.

9) Obstruction of Proceedings Before Departments, Agencies and Committees (18 U.S.C. §1505)

Whoever, with intent to avoid, evade, prevent, or obstruct compliance, in whole or in part, with "any civil investigative demand duly and properly made under the Antitrust Civil Process Act, willfully withholds, misrepresents, removes from any place, conceals, covers up, destroys, mutilates, alters, or by other means falsifies any documentary material, answers to written interrogatories, or oral testimony, which is the subject of such demand; or attempts to do so or solicits another to do so shall be fined under this title, imprisoned not more than 5 years".[79]

10) Destruction, Alteration, or Falsification of Records in Federal Investigations and Bankruptcy (18 U.S.C. §1519)

Whoever knowingly alters, destroys, mutilates, conceals, covers up, falsifies, or makes a false entry in any record, document, or tangible object with the intent to impede, obstruct, or influence the investigation or proper administration of any matter within the jurisdiction of any department or agency of the United States or any case filed under title 11, or in relation to or contemplation of any such matter or case, shall be fined under this title, imprisoned not more than 20 years, or both.[80]

11) Frauds and Swindles (18 U.S.C. § 1341)[81]

Whoever devises a scheme to defraud, or obtain money or property "by means of false or fraudulent pretenses, representations, or promises"[82] 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

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[74] 18 U.S.C. § 1001 [a][3].
[75] 18 U.S.C. § 1001.
[76] 18 U.S.C. § 1035.
[77] 18 U.S.C. § 1035 [a][1].
[78] 18 U.S.C. § 1035 [a][2].
[79] 18 U.S.C. § 1505.
[80] 18 U.S.C. §1519.
[81] 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.
[82] 18 U.S.C. § 1341.

service (*e.g.*, UPS, FedEx) shall be fined, imprisoned not more than 20 years, or both.[83] Note that this law also applies to any person who takes or receives therefrom, any such matter or item.[84]

12) Fraud by Wire, Radio and Television (18 U.S.C. § 1343)[85]

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.[86]

13) 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, directly or indirectly, in any 1 year period under a contract or subcontract, shall be fined, or imprisoned not more than 5 years, or both.[87]

14) 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.[88]

15) 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…"[89] 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.[90]

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[83] 18 U.S.C. § 1341.
[84] *Id.*
[85] *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).
[86] 18 U.S.C. § 1343.
[87] 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.*
[88] 18 U.S.C. § 1518.
[89] 18 U.S.C. § 1956 [a][1].
[90] *Id.*

16) 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 any benefit or payment under a Federal health care program;[91] 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.[92] 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.[93]

17) 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"[94] 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 $100,000 or imprisoned for not more than 10 years, or both.[95]

II. STATE OF CONNECTICUT LAWS

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,[96] 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.)[97]

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[91] 42 U.S.C. § 1320a-7b(a)[1] .
[92] 42 U.S.C. § 1320a-7b(a)[5] .
[93] 42 U.S.C. § 1320a-7b [a].
[94] 42 U.S.C. § 1320a-7b.
[95] 42 U.S.C. § 1320a-7b.
[96] 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].
[97] *See also* R.C.S.A. § 17-83k-1 et. seq.

A person commits vendor fraud when, such person provides goods or services to a Medicaid beneficiary,[98] and does one of the following with the intent to defraud:

- submits a false claim for goods or services performed;[99]
- 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; [100]
- solicits to perform unnecessary services for or sell unnecessary goods to any such beneficiary; [101]
- sells goods to or performs services for any such beneficiary without prior authorization when required by the Department of Social Services; [102] or
- accepts additional compensation in excess of the amount authorized by law from any person or source other than the state.[103]

Penalties range from a class B felony[104] (e.g. receipt of payment in excess of ten thousand dollars) to class C misdemeanor[105] (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.[106]

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."[107]

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

[98] 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.
[99] C.G.S.A. § 53a-290 [1].
[100] C.G.S.A. § 53a-290 [2].
[101] C.G.S.A. § 53a-290 [3].
[102] C.G.S.A. § 53a-290 [4].
[103] 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.
[104] *See* C.G.S.A. §53a-291.
[105] *See* C.G.S.A. § 53a-296.
[106] C.G.S.A. §17b-99 [a].
[107] C.G.S.A. § 17b-127 [a].

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 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.[108]

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.[109]

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)[110] 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;"[111] 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.[112]

Insurance fraud is a class D felony.[113]

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[108] C.G.S.A. § 53-442.
[109] C.G.S.A. § 53-443.
[110] C.G.S.A. § 53a-215 [b].
[111] C.G.S.A. § 53a-215 [a].
[112] C.G.S.A. § 53a-215 [a].
[113] *Id.*

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

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.[114] Penalties for larceny range from a class B felony[115] (*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[116] (*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. [117]

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.[118]

False statement is a class A misdemeanor. [119]

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

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."[120]

Tampering with or fabricating physical evidence is a class D felony.[121]

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[114] *See* C.G.S.A. § 53a-119.
[115] *See* C.G.S.A. § 53a-122 [a].
[116] *See* C.G.S.A. § 53a-125b[a].
[117] *See* C.G.S.A. § 53a-157b.
[118] *See* C.G.S.A. § 53a-146 [3].
[119] *See* C.G.S.A. § 53a-157b.
[120] C.G.S.A. § 53a-155 [a].
[121] 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.

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

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.[122]

Paying a kickback is a class D felony.[123]

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.[124]

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.[125]

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.[126]

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[122] C.G.S.A. § 53a-161d [a].
[123] *Id.*
[124] C.G.S.A. § 4-275.
[125] *Id.*
[126] *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 percent 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.*

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

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.[127]

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.[128]

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.[129]

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. [130]

A practitioner that violates this law is subject to disciplinary action under subdivision (7) of subsection (a) of section 19a-17. [131]

III. STATE OF NEW YORK LAWS[132]

New York False Claim Laws fall under the jurisdiction of both New York's civil and administrative laws as well as its criminal laws. Some apply to recipient false claims and some apply to provider false claims. The majority of these statutes are specific to healthcare or Medicaid. Yet some of the "common law" crimes apply to areas of interaction with the government and so are applicable to health care fraud and will be listed in this section.

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[127] C.G.S.A. § 20-7a [c].
[128] *Id.*
[129] *Id.*
[130] *Id.*
[131] *Id.*
[132] Section III is duplicated from New York State Office of the Medicaid Inspector General ("OMIG"), Federal & New York Statutes Relating to the Filing of False Claims, which was previously available on the OMIG website at https://upload/general_pages_docs/document/relevant_fca_statutes_122209.pdf (last accessed 9/28/21).

A. Criminal Laws

1) New York State Social Services Law, Section 145 – Penalties

Any person who submits false statements or deliberately conceals material information in order to receive public assistance, including Medicaid, is guilty of a misdemeanor.

2) New York State Social Services Law, Section 366-b – Penalties for Fraudulent Practices

Any person who obtains or attempts to obtain, for himself or others, medical assistance by means of a false statement, concealment of material facts, impersonation or other fraudulent means is guilty of a class A misdemeanor.

Any person who, with intent to defraud, presents for payment a false or fraudulent claim for furnishing services, knowingly submits false information to obtain greater Medicaid compensation, or knowingly submits false information in order to obtain authorization to provide items or services is guilty of a class A misdemeanor.

3) New York State Penal Law Article 155- Larceny

The crime of larceny applies to a person who, with intent to deprive another of his property, obtains, takes or withholds the property by means of trick, embezzlement, false pretense, false promise, including a scheme to defraud, or other similar behavior. This statute has been applied to Medicaid fraud cases.

- Fourth degree grand larceny involves property valued over $1,000. It is a class E felony.
- Third degree grand larceny involves property valued over $3,000. It is a class D felony.
- Second degree grand larceny involves property valued over $50,000. It is a class C felony.
- First degree grand larceny involves property valued over $1 million. It is a class B felony.

4) New York State Penal Law Article 175 – False Written Statements

Four crimes in this Article relate to filing false information or claims and have been applied in Medicaid fraud prosecutions:

- § 175.05 - Falsifying business records involves entering false information, omitting material information or altering an enterprise's business records with the intent to defraud. It is a class A misdemeanor.

- §175.10 - Falsifying business records in the first degree includes the element of the §175.05 offense and includes the intent to commit another crime or conceal its commission. It is a class E felony.

- §175.30 - Offering a false instrument for filing in the second degree involves presenting a written instrument, including a claim for payment, to a public office knowing that it contains false information. It is a class A misdemeanor.

- §175.35 - Offering a false instrument for filing in the first degree includes the elements of the second degree offense and must include an intent to defraud the state or a political subdivision. It is a class E felony.

5) New York State Penal Law Article 176 – Insurance Fraud

This law applies to claims for insurance payments, including Medicaid or other health insurance, and contains six crimes:

- Insurance Fraud in the 5th degree involves intentionally filing a health insurance claim knowing that it is false. It is a class A misdemeanor.

- Insurance fraud in the 4th degree is filing a false insurance claim for over $1,000. It is a class E felony.

- Insurance fraud in the 3rd degree is filing a false insurance claim for over $3,000. It is a class D felony.

- Insurance fraud in the 2nd degree is filing a false insurance claim for over $50,000. It is a class C felony.

- Insurance fraud in the 1st degree is filing a false insurance claim for over $1 million. It is a class B felony.

- Aggravated insurance fraud is committing insurance fraud more than once. It is a class A felony.

6) New York State Penal Law Article 177 – Health Care Fraud

This statute, enacted in 2006, applies to health care fraud crimes. It was designed to address the specific conduct by health care providers who defraud the system including any publicly or privately funded health insurance or managed care plan or contract, under which any health care item or service is provided. Medicaid is considered to be a single health plan under this statute.

This law primarily applies to claims by providers for insurance payment, including Medicaid payment, and it includes six crimes.

- Health care fraud in the 5th degree – a person is guilty of this crime when, with intent to defraud a health plan, he or she knowingly and willfully provides materially false information or omits material information for the purpose of requesting payment from a health plan. This is a class A misdemeanor.

- Health care fraud in the 4th degree – a person is guilty of this crime upon filing such false claims on more than one occasion and annually receives more than three thousand dollars. This is a class E felony.

- Health care fraud in the 3rd degree – a person is guilty of this crime upon filing such false claims on more than one occasion and annually receiving over ten thousand dollars. This is a class D felony.

- Health care fraud in the 2nd degree - a person is guilty of this crime upon filing such false claims on more than one occasion and annually receiving over fifty thousand dollars. This is a class C felony.

- Health care fraud in the 1st degree - a person is guilty of this crime upon filing such false claims on more than one occasion and annually receiving over one million dollars. This is a class B felony.

B. Civil and Administrative Laws

1) New York False Claims Act (State Finance Law Sections 187-194)

The New York False Claims Act is similar to the Federal False Claims Act. It imposes penalties and fines upon individuals and entities who knowingly file false or fraudulent claims for payment from any state or local government, including health care programs such as Medicaid. It also has a provision regarding reverse false claims similar to the federal FCA such that a person or entity will be liable in those instances in which the person obtains money from a state or local government to which he may not be entitled, and then uses false statements or records in order to retain the money.

The penalty for filing a false claim is six to twelve thousand dollars per claim plus three times the amount of the damages which the state or local government sustains because of the act of that person. In addition, a person who violates this act is liable for costs, including attorneys' fees, of a civil action brought to recover any such penalty.

The Act allows private individuals to file lawsuits in state court, just as if they were state or local government parties, subject to various possible limitations imposed by the NYS Attorney General or a local government. If the suit eventually concludes with payments back to the government, the person who started the case can recover twenty-five to thirty percent of the proceeds if the government did not participate in the suit, or fifteen to twenty-five percent if the government did participate in the suit.

2) New York State Social Services Law, Section 145-b – False Statements

It is a violation to knowingly obtain or attempt to obtain payment for items or services furnished under any Social Services program, including Medicaid, by use of a false statement, deliberate concealment or other fraudulent scheme or device. The state or the local Social Services district may recover three times the amount incorrectly paid. In addition, the Department of Health may impose a civil penalty of up to ten thousand dollars per violation. If repeat violations occur within five years, a penalty of up to thirty thousand dollars per violation may be imposed if the repeat violations involve more serious violations of Medicaid rules, billing for services not rendered, or providing excessive services.

3) New York State Social Services Law, Section 145-c – Sanctions

If any person applies for or receives public assistance, including Medicaid, by intentionally making a false or misleading statement, or intending to do so, the needs of the individual or that of his family shall not be taken into account for the purpose of determining his or her needs or that of his family for six months if a first offense, for twelve months if a second offense (or if benefits wrongfully received are at least one thousand dollars but not more than three thousand nine hundred dollars), for eighteen months if a third offense (or if benefits wrongfully received are in excess of three thousand nine hundred dollars), and five years for any subsequent occasion of any such offense.

IV. 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 for compliance reports or complaints made in good faith.[133]

[133] Note that, under the Health Insurance Portability and Accountability Act (HIPAA), a workforce member, is permitted to disclose protected health information when the workforce member believes in good faith that the covered entity (as defined under HIPAA) has engaged in conduct that is unlawful or otherwise violates professional or clinical standards, or that the care, services, or conditions provided by the covered entity potentially endangers one or more patients, workers, or the public, when such disclosure is made to a healthcare oversight agency or to the workforce member's attorney. 45 CFR § 164.502[j][1][i-ii]. Such disclosures must be limited to the minimum necessary to accomplish the intended purpose of the disclosure (s*ee* 45 CFR § 164.502[b][1]&[2]) and cannot otherwise be in violation of other Federal laws or more stringent state laws related to the privacy of individually identifiable health information. *See* 45 CFR § 160.203.

A. FEDERAL PROTECTIONS

1) Federal False Claims Act (31 U.S.C. §3730[h])[134]

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.[135]

2) Federal Occupational Safety and Health Act of 1990 (29 USC 660 (c))

In general, the Occupational Safety and Health Act ("OSHA Act") protects workforce members from retaliation who complain to such workforce members' employers, Occupational Safety and Health Administration, or certain other government agencies about unsafe or unhealthy working conditions in the workplace, or who otherwise exercise various other rights under the OSHA Act.[136]

B. STATE OF CONNECTICUT LAWS

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.[137]

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[134] 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 sub grantees 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."[134]

[135] *See* 31 U.S.C. § 3730[h].

[136] *See* 29 USC 660[c].

[137] 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.*

The provisions of this subsection shall not be applicable when the employee knows that such report is false.[138]

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.[139] 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.[140]

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 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.[141]

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]."[142] Further, affected employees may seek any additional remedies available to them under applicable Federal or State law.[143]

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

Each foundation[144] 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

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[138] C.G.S.A. § 31-51m [a].
[139] *Id. See also* R.C.S.A. § 4-61dd-1.
[140] *Id. See also* R.C.S.A. § 4-61dd-1.
[141] 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].
[142] C.G.S.A. §19a-498a [c].
[143] *Id*. at §19a-498a [d].
[144] 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

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.[145]

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.[146]

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.

C. STATE OF NEW YORK LAWS[147]

1) New York State False Claim Act (State Finance Law Section 191)

The New York State False Claim Act also 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 Act. Remedies include reinstatement with comparable seniority as the qui tam relator would have had but for the discrimination, two times

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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.*

[145] C.G.S.A. § 4-37j.

[146] C.G.S.A. § 31-51q.

[147] Paragraph 1 of § IV(C) is duplicated from OMIG's Federal & New York Statutes Relating to the Filing of False Claims, which was previously available at: **http://www.omig.ny.gov/images/stories/relevant_fca_statutes_122209.pdf** (last accessed 9/28/20).

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.

2) New York State Labor Law, Section 740

An employer may not take any retaliatory action against an employee if the employee discloses information about the employer's policies, practices, or activities to a regulatory, law enforcement or other similar agency or public official. The term "employee" used in § 740 includes Any person, "***including former employees, or natural persons employed as independent contractors to carry out work in furtherance of an employer's business enterprise who are not themselves employers***", who receives compensation, whether in the form of wages or another instrumentality of remuneration, for the performance of "services for and under the control and direction of an employer . . . ."[148]

Protected disclosures are those that assert that the employer is in violation of a law, rule, or regulation that the reporting "***employee reasonably believes poses a substantial and specific danger to the public health or safety***"[149] The employee's disclosure is protected only if the employee first brought up the matter with a supervisor and gave the employer a reasonable opportunity to correct the alleged violation. Such notification is not required where: "(a) there is an imminent and serious danger to the public health or safety; (b) the employee reasonably believes that reporting to the supervisor would result in a destruction of evidence or other concealment of the activity, policy or practice [being reported]; (c) such activity, policy or practice could reasonably be expected to lead to endangering the welfare of a minor; (d) the employee reasonably believes that reporting to the supervisor would result in the physical harm to the employee or any other person; or (e) the employee reasonably believes that the supervisor is already aware of the activity, policy or practice and will not correct such activity, policy or practice."[150]

If an employer takes a retaliatory action against the employee, the employee may sue "in a court of competent jurisdiction" for, among other things, the following:[151]

(i) reinstatement "of the employee to the same position held before the retaliatory action or to an equivalent position;

(ii) "reinstatement of full fringe benefits and seniority rights";

(iii) any lost back wages and benefits and "reasonable costs, disbursements, and attorneys' fees";

(iv) reinstatement of full fringe benefits and seniority rights;

(v) "an injunction to restrain continued violation of [Labor Law § 740] . . . ."

[148] Labor Law § 740 [1][a] [emphasis added]
[149] Labor Law § 740 [2][a] [emphasis added].
[150] Labor Law § 740 [3]
[151] Labor Law § 740 [4], [5][a-e].

In addition to the above, a court of competent jurisdiction may order, as part of relief "a civil penalty of an amount not to exceed [$10,000]", as well as "the payment by the employer of punitive damages, if the violation was willful, malicious or wanton."[152]

Note, a court of competent jurisdiction may also award "reasonable attorneys' fees and court costs and disbursements to an employer" where an employee brings an action under Labor Law 740 in bad faith.[153]

3) New York State Labor Law, Section 741

Labor Law § 741 prohibits healthcare employers from taking retaliatory action against any employee because the employee either: "(a) discloses or threatens to disclose to a supervisor, a public body, a news media outlet, or a social media forum available to the public at large, an activity, policy or practice of the employer or agent that the employee, in good faith, reasonably believes constitutes improper quality of patient care or improper quality of workplace safety; or (b) objects to, or refuses to participate in any activity, policy or practice of the employer or agent that the employee, in good faith, reasonably believes constitutes improper quality of patient care or improper quality of workplace safety."[154]

Note, under § 741, and employee is defined as ***"any person who performs health care services for and under the control and direction of any public or private employer which provides health care services for wages or other remuneration***."[155]

An employee may seek, through a court of competent jurisdiction, the same relief under § 741 as may be sought under Labor Law § 740, as outlined directly above in § [IV][C][2] of this Appendix.[156]

4) New York State Not-For-Profit Corporation, Section 715-b

The board of every corporation that has twenty or more employees and in the prior fiscal year had annual revenue in excess of one million dollars shall adopt, and oversee the implementation of, and compliance with, a whistleblower policy to protect from retaliation persons who report suspected improper conduct. Such policy shall provide that no director, officer, employee or volunteer of a corporation who in good faith reports any action or suspected action taken by or within the corporation that is illegal, fraudulent or in violation of any adopted policy of the corporation shall suffer intimidation, harassment, discrimination or other retaliation or, in the case of employees, adverse employment consequence.[157]

The whistleblower policy shall include the following provisions:

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[152] Labor Law § 740 [5][f-g]
[153] Labor Law § 740 [6]
[154] Labor Law § 741 [2][a-b]; see also 741 [1][b]["Employer" defined].
[155] Labor Law § 741 [1][a][emphasis added].
[156] *See* Labor Law § 741 [4]; *see also* Labor Law § 740 [4], [5][a-e].
[157] *See* NOT-FOR-PROFIT CORP. § 715-b(a).

- Procedures for the reporting of violations or suspected violations of laws or corporate policies, including procedures for preserving the confidentiality of reported information;[158]

- A requirement that an employee, officer or director of the corporation be designated to administer the whistleblower policy and to report to the board or an authorized committee thereof, except that directors who are employees may not participate in any board or committee deliberations or voting relating to administration of the whistleblower policy;[159]
- A requirement that the person who is the subject of a whistleblower complaint not be present at or participate in board or committee deliberations or vote on the matter relating to such complaint;[160] and

- A requirement that a copy of the policy be distributed to all directors, officers, employees and to volunteers who provide substantial services to the corporation.[161]

5) New York State Labor Law, Section 215

An employer is prohibited from discharging, threatening, penalizing, or in any other manner discriminating or retaliating against any employee because such employee has made a complaint to his or her employer, or to the New York State Commissioner of Labor or the New York State Attorney General, that the employer has engaged in conduct that the employee, reasonably and in good faith, believes is in violation of New York State Department of Labor laws.[162]

The civil penalty for a violation is up to twenty thousand dollars. Furthermore, an employer may be found guilty of a class B misdemeanor for violation of subdivision 1 of Social Services § 215.

6) New York Social Services Law, Section 363-d

Under this provision, providers of medical assistance program items and services must adopt and implement a compliance program that includes a policy of non-intimidation and non-retaliation for good faith participation in the compliance program, including but not limited to reporting potential issues, investigating issues, self-evaluations, audits and remedial actions, and reporting to appropriate officials as provided in sections seven hundred forty and seven hundred forty-one of the labor law.[163]

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[158] *See* NOT-FOR-PROFIT CORP. § 715-b(b)(1).
[159] *See* NOT-FOR-PROFIT CORP. § 715-b(b)(2).
[160] *See* NOT-FOR-PROFIT CORP. § 715-b(b)(3).
[161] *See* NOT-FOR-PROFIT CORP. § 715-b(b)(4).
[162] *See* Social Services Law § 215[1][a][i]. Note that the law further protects employees that, among other things, participate in proceedings or investigations as witnesses, or otherwise provides information to the New York State Commissioner of Labor. *See* Social Services Law § 215[1][a][iv] & [v].
[163] *See* Social Services Law § 363-d[2][h].

7) New York Social Services Law, Section 460-d

A nursing home facility, as defined under State law, found responsible for an act of retaliation or reprisal against any resident, employee, or other person for having filed a complaint with or having provided information to any long term care patient ombudsman shall be subject to civil penalties up of up to one thousand dollars per day per violation.[164]

[164] SOCIAL SERVICES LAW § 460-d[7][a]; *see also* SOCIAL SERVICES LAW § 460-d[7][b][2][vi].

APPENDIX "B"[1]

NUVANCE HEALTH CORPORATE COMPLIANCE OFFICE

Summary of New York and Federal Laws and Government Policies that Apply to the Nuvance Health Compliance and Ethics Program Related to Fraud, Waste and Abuse Prevention Program For Risk Areas Concerning Federal Healthcare Programs

(Revised 4-30-2023; 6-25-2023; 6-30-2023)

June 30, 2023

[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 Nuvance Health Corporate Compliance Office for any questions regarding the content contained herein

New York and Federal Laws and Government Policies that Apply to the Compliance /Fraud, Waste and Abuse Prevention Program Risk Areas Concerning Federal Healthcare Programs (*Revised 4-30-2023; 6-25-2023; 6-30-2023*)

Risk Area	Federal	New York
Risk Areas Covered Under 18 NYCRR Part 521 (New York *Fraud, Waste and Abuse Prevention Program* regulations)		
Billings[2] including claims preparation and submission	➢ 42 USC 1396a [a][68][A] - Employee and contractor education provisions of the Deficit Reduction Act of 2005	➢ New York State Medicaid Program Information for All Providers General Billing (https://www.emedny.org/providermanuals/allproviders/pdfs/information_for_all_providers-general_billing.pdf) ➢ New York State General Billing Guidelines https://www.emedny.org/providermanuals/allproviders/General_Billing_Guidelines_Professional.pdf ➢ New York State Department of health eMedNY Provider Manuals https://www.emedny.org/providermanuals/ ➢ New York State Department of Health eMedNY Inpatient Billing Manual https://www.emedny.org/ProviderManuals/Inpatient/index.aspx

[2] *See* 18 NYCRR § 521-1.3 [d][1]

		➢ 18 NYCRR Part 500 – Medical care authorized under the N.Y. Medicaid Program (https://regs.health.ny.gov/volume-c-title-18/1857795274/part-500-general-provisions) ➢ 18 NYCRR Part 505 (Medical Care) (https://regs.health.ny.gov/volume-c-title-18/content/part-505-medical-care) ➢ 18 NYCRR Part 506 (Dental Care) (https://regs.health.ny.gov/volume-c-title-18/1451168627/part-506-dental-care) ➢ 18 NYCRR Part 515 – Provider Sanctions (https://regs.health.ny.gov/volume-c-title-18/380923394/part-515-provider-sanctions) • 18 NYCRR 515.2 (Unacceptable practices under the medical assistance program) ✓ *18 NYCRR 515.2 [b][1] & [b][2] (Submission of false claims and statements*) ✓ *18 NYCRR 515.2 [b][5] – Prohibition of bribes, kickbacks, rebates, discounts, referral fees*) ✓ *18 NYCRR 515.2 [b][8] Prohibition of receiving additional payments (e.g., gifts, money, donations, or other consideration) beyond that authorized under Federal healthcare program requirement for a submitted claim*)

		➢ 18 NYCRR Part 540 - Authorization of Medical Care under the NYS Medicaid Program (https://regs.health.ny.gov/volume-c-title-18/2053539703/part-540-authorization-medical-care) • 18 NYCRR 540.6 - Billing for Medicaid • 18 NYCRR 540.7 – Requirements for billing under Medicaid ➢ Emergency Medical Services and Surprise Bills Laws and New York State Department of Health Policies (https://www.health.ny.gov/regulations/public_health_law/surprise bill law/)
Payments[3] and claims reimbursement, patient collections	42 USC 1395y – Exclusions from Coverage and Medicare as Secondary Payer	➢ 18 NYCRR 504.8 – Providers are subject to audit and review by the NYS Department of Health (https://regs.health.ny.gov/content/section-5048-audit-and-claim-review) ➢ See ***Billings*** above
Ordered Services[4] (the ordering, furnishing, delivering, administration, directing, or otherwise providing	➢ See Billings and Payments above	➢ See Billings and Payments above ➢ Education Law, Title 8, The Professions (https://www.nysenate.gov/legislation/laws/EDN/T8) • Education Law Article 131, Medicine • Education Law, Article 133, Dentistry

[3] *See* 18 NYCRR § 521-1.3 [d][2]
[4] *See* 18 NYCRR §521-1.3 [d][3]

Federal healthcare items or services**)**		• Education Law, Article 132, Chiropractic • Education Law, Article 143 Optometry ➢ Education Law 6902 [3][a][ii-v] (https://www.nysenate.gov/legislation/laws/EDN/6902), Education Law 6910 https://www.nysenate.gov/legislation/laws/EDN/6910), and New York State eMedNY Nurse Practitioner Manual (https://www.emedny.org/providermanuals/nursepractitioner/index.aspx)
Medical necessity[5] **and medical record documentation**	42 CFR § 482.24 Condition of Participation – Medical Record services (eCFR :: 42 CFR Part 482 -- Conditions of Participation for Hospitals)	➢ 10 NYCRR 405.10 – Hospital medical Records (https://regs.health.ny.gov/content/section-40510-medical-records) ➢ 18 NYCRR 504. 3 [a], [e], [h] - Duties of Provider enrolled in Medicaid program – maintenance of contemporaneous and accurate medical records, submission of only appropriate claims for medically necessary services - (https://regs.health.ny.gov/content/section-5043-duties-provider) ➢ 18 NYCRR 515.2 [b][6] (Unacceptable record keeping) (https://regs.health.ny.gov/content/section-5152-unacceptable-practices-under-medical-assistance-program) ➢ 18 NYCRR 515.2 [b][11] - Excessive services https://regs.health.ny.gov/content/section-5152-

[5]*See* 18 NYCRR § 521-1.3 [d][4]

		unacceptable-practices-under-medical-assistance-program) ➢ 18 NYCRR 515.2 [b][12] (Failure to meet professionally recognized standards for health care) (https://regs.health.ny.gov/content/section-5152-unacceptable-practices-under-medical-assistance-program)
Quality of Care[6]	➢ 42 CFR 482.21 – Quality Assessment and Performance Improvement Program ➢ 42 CFR 482.30 Utilization Review (see https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-482/subpart-C/section-482.30) ➢ 42 CFR 482.43 – CMS Condition of Participation – Discharge Planning (eCFR :: 42 CFR Part 482 -- Conditions of Participation for Hospitals)	➢ Public Health Law 2805-J – Medical, dental and podiatric malpractice prevention program (see https://www.nysenate.gov/legislation/laws/PBH/2805-J) ➢ Public Health Law 2805-K – Investigations prior to granting or renewing privileges https://www.nysenate.gov/legislation/laws/PBH/2805-K ➢ Public Health Law 2805-L – Adverse Event Reporting – (see https://www.nysenate.gov/legislation/laws/PBH/A28) ➢ Public Health Law 2805-M – Confidentiality of Medical Malpractice Prevention Program information (see https://www.nysenate.gov/legislation/laws/PBH/2805-M) ➢ 10 NYCRR 405.6 – Establishment of a Quality Assurance Program (https://regs.health.ny.gov/content/section-4056-quality-assurance-program)

[6] *See* 18 NYCRR § 521-1.3 [d][5]

		➢ 10 NYCRR 405.8 – Adverse Event Reporting (see https://regs.health.ny.gov/content/section-4058-adverse-event-reporting) ➢ 10 NYCRR 405.26 – Utilization Review (see https://regs.health.ny.gov/content/section-40526-utilization-review) ➢ 10 NYCRR 405.9 – Admission/discharge of patients (https://regs.health.ny.gov/content/section-4059-admissiondischarge) ➢ 10 NYCRR 405.7 – Patient rights ➢ Mental Hygiene Facilities 14 NYCRR 524.6 – Incident Management Program – (see https://govt.westlaw.com/nycrr/Document/I5035fc44cd1711dda432a117e6e0f345?viewType=FullText&originationContext=documenttoc&transitionType=CategoryPageItem&contextData=(sc.Default)) ➢ 14 NYCRR 524.7 – Incident Reporting Requirements https://govt.westlaw.com/nycrr/Document/I5035fc41cd1711dda432a117e6e0f345?viewType=FullText&originationContext=documenttoc&transitionType=CategoryPageItem&contextData=(sc.Default)
Governance[7]	42 CFR 482.12 – Governing Body Requirement	10 NYCRR 405.2(a-h) – Hospital Governing Body New York State Not-for-Profit Corporations, Article 7 (https://www.nysenate.gov/legislation/laws/NPC/A7)

[7] *See* 18 NYCRR § 521-1.3 [d][6]

Mandatory reporting[8] and Refunding of Overpayments	42 USC § 1320a-7k[d] – Reporting and Returning of Overpayments (https://www.govinfo.gov/content/pkg/USCODE-2010-title42/pdf/USCODE-2010-title42-chap7-subchapXI-partA-sec1320a-7k.pdf) 42 CFR §§ 401.301 et seq. – Reporting and Returning of Overpayments (https://www.govinfo.gov/content/pkg/CFR-2019-title42-vol2/pdf/CFR-2019-title42-vol2-sec401-305.pdf)	Social Services Law 363-d [6], [7] – Provider Compliance Program and Overpayments (https://www.nysenate.gov/legislation/laws/SOS/363-D) 18 NYCRR 515.9 (Overpayments) (https://regs.health.ny.gov/content/section-5159-overpayments) 18 NYCRR 521-3.1 (Self-Disclosure Program/Overpayments) (https://omig.ny.gov/media/80411) OMIG Overpayment Self-Disclosure Program Guidance (https://omig.ny.gov/media/80831/) OMIG Overpayment Self-Disclosure Program FAQs (https://omig.ny.gov/submission-checklist-and-faqs) OMIG Overpayment Self-Disclosure Program Form and Instructions (https://omig.ny.gov/self-disclosure-submission-information-and-instructions) 18 NYCRR 521-1.4(g) – Excluded Providers Screening Requirement (https://omig.ny.gov/media/80411)
Credentialing[9]	➢ See provider/entity sanction screening below	➢ 10 NYCRR 405.4 - Medical Staff

[8] *See* 18 NYCRR § 521-1.3 [d][7]
[9] *See* 18 NYCRR § 521-1.3 [d][8]

	➢ 42 CFR Part 482 – CMS Conditions of Participation for Hospitals (eCFR :: 42 CFR Part 482 -- Conditions of Participation for Hospitals) • 42 CFR 482.13 – Patient rights • 42 CFR 482.22 – CMS Conditions of Participation Medical Staff • 42 CFR 482.23 – Nursing Staff • 42 CFR 482.25 – Pharmacy Staff • 42 CFR 482.26 – Radiology Staff	➢ 10 NYCRR 405.3 – Hospital administration (https://regs.health.ny.gov/content/section-4053-administration) ➢ Education Law, Title 8 (medical, clinical and allied health professions) Articles 130-143, 153-160, 163-168 (https://www.nysenate.gov/legislation/laws/EDN/T8)
Contractor Oversight[10] And Excluded Provider/Entity and Sanction Screening	➢ 42 USC § 1320a-7 – Exclusion of certain individuals and entities from participation in Medicare and State healthcare programs (https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title42-section1320a-7&num=0&edition=prelim) ➢ HHS OIG Exclusion Authorities – Scope, Mandatory Exclusions, and Permissive Exclusions (https://oig.hhs.gov/exclusions/authorities.asp) ➢ 42 USC 1396a [a][68][A] - Employee and contractor education provisions of the Deficit Reduction Act of 2005	➢ 18 NYCRR Part 505 ➢ 18 NYCRR 515.5 - Sanctions, excluded persons/entities (https://regs.health.ny.gov/content/section-5155-sanctions-effect) ➢ 18 NYCRR 515.7 [b] - Immediate sanctions (https://regs.health.ny.gov/content/section-5157-immediate-sanctions) ➢ 18 NYCRR 515.8 - Mandatory exclusions (https://regs.health.ny.gov/content/section-5158-mandatory-exclusions) ➢ 18 NYCRR 515.2 [b][7] (Employment of sanctioned persons) (https://regs.health.ny.gov/content/section-5152-unacceptable-practices-under-medical-assistance-program)

[10] *See* 18 NYCRR § 521-1.3 [d][9]; *see also* 10 NYCRR §§ 400.4, 405.2 [h], 42 USC § 1396a [a][68][A];

	➢ Civil Monetary Penalties, Assessments and Exclusions – 42 CFR Part 402 (https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-A/part-402)	➢ 18 NYCRR 521-1.4(g) – Excluded Providers Screening Requirement (https://omig.ny.gov/media/80411)
Other Risk Areas that may be identified through experience[11] (Note that this list is not exclusive. Nuvance Health updates these categories routinely as part of our Compliance and Ethics Program's ongoing risk assessment activities, as well as on an ongoing basis as potential areas of risk relative to the healthcare industry and entities receiving of Federal healthcare program funds).		
	➢ Stark Law (*See* Appendix "A", p.14) ➢ U.S. Department of Health & Human Services Guidance Portal Physician Self-Referral (https://www.hhs.gov/guidance/document/physician-self-referral) ➢ Anti-Kickback Statute (*See* Appendix "A", pgs. 14-15) ➢ HIPAA Privacy, Security, and Breach Notification Rules (45 CFR Part 164, Subparts C, D & E) (https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-C/part-164?toc=1)	Article 39 of the N.Y. General Business Law – Breach notification & Data Security Protections (https://www.nysenate.gov/legislation/laws/GBS/A39-F)

[11] *See* 18 NYCRR § 521-1.3 [d][10]