

Classification: Compliance - General	ADMINISTRATIVE POLICIES & PROCEDURES	
Yale New Haven Health System: Yale-New Haven Hospital / Bridgeport Hospital / Greenwich Hospital		
Title: False Claims and Payment Fraud Prevention		Policy Number: CC:R-33
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Distribution: YNHHS Intranet Policies – Corporate Compliance		Policy Type: I
Supersedes: None		

PURPOSE

The purpose of this policy is to inform employees, contractors, and agents of Yale-New Haven Hospital, Bridgeport Hospital, and Greenwich Hospital (“the Hospital”) of the federal False Claims Act (referenced in this policy as "FCA")¹ and to provide general information regarding the Hospital’s efforts to combat fraud, waste, and abuse in the Hospital and to describe the remedies and fines for violations that can result from certain types of fraudulent activities.

POLICY

Reporting Fraud, Waste, or Abuse

All employees, contractors, agents, and volunteers of the Hospital must immediately report to the System Compliance and Privacy Officer, any suspicion of fraud, waste, or abuse in connection with the business of the Hospital. The Hospital engages in specific compliance efforts to detect and prevent fraud, waste, and abuse, such as the Corporate Compliance Program.

If you would like more information on the Corporate Compliance Program and specific compliance policies or on how to report any concerns, please contact the Office of Privacy and Corporate Compliance (203-688-8416). Compliance Policies may also be accessed via the Yale New Haven Health System Intranet.²

Detailed Information of the Federal False Claims Act

The Federal False Claims Act (FCA) imposes civil penalties on people and companies who knowingly submit a false claim or statement to a federally-funded program or otherwise conspire to defraud the government in order to receive payment. It also protects people who make efforts to stop the suspected fraud.

¹ Reference to the Federal False Claims Act includes the amendments made to the Act by the Fraud Enforcement and Recovery Act of 2009.

² <http://intranet.mis.ynhh.com/ynhhs/corpcompliance/index.asp>

The FCA is not confined to healthcare claims, but extends to any payment requested of the federal government or the federal government's contractor, grantee, or other party, if the payment is to be spent or used on the government's behalf or to advance a government program or interest and the government provides any portion of the payment or will reimburse the contractor, grantee, or other party. The FCA applies to billing and claims sent from the Hospital to any government payor program, including Medicare and Medicaid.

It is the policy of the Hospital that an employee, contractor, or agent of the Hospital who knowingly and intentionally submits a false claim will be reported to the necessary authorities. Anyone or any company that submits a false claim or statement to the government may be fined under the FCA between \$5,500 and \$11,000 for each such claim submitted, regardless of the size of the false claim, and the person or company could be required to pay an additional fine of three times the value of any charges.

Part of the FCA's purpose is to create an environment where employees and others feel safe reporting concerns about fraud. The Hospital fully supports that goal. Any person who lawfully attempts to stop any FCA violations or reports information about false claims or suspected false claims that are submitted by others, may not be retaliated against, demoted, suspended, threatened, or harassed by the Hospital for such actions. The FCA also protects individuals who assist in an investigation, provide testimony, or participate in the government's handling of a false claim.

The FCA provisions are generally enforced by the U.S. Department of Justice. The FCA provides that a person may initiate a formal claim if he or she is the "original source" of the information. This means that the person bringing the claim must have direct and independent knowledge of the alleged fraud. If any funds are recovered, a portion of the funds may be paid to the person who initiated the formal claim, at the discretion of a federal court. This amount, if awarded, generally is between 15% and 30% of the total damage amount.

If a person wishes to file a claim regarding fraud or suspected fraud related to a healthcare payment directly with the government, he or she must first present a formal complaint, along with all material evidence relating to the alleged fraud, to the authorities at the U.S. Department of Justice. The authorities have 60 days to investigate, during which time the complaint is kept confidential. Upon completion of the investigation, the government will decide either to pursue the case on its own or decline to proceed with the case. If the federal government declines the case, the individual may still proceed with the case on his or her own, but without the government's assistance, and at his or her own expense.

A private legal action under the FCA must be brought within six years from the date that the false claim was submitted to the government. (A government-initiated claim may be brought up to ten years after the false claim, depending on the circumstances.)

Detailed Information of the Federal Program Fraud Civil Remedies Act

Persons or companies that commit fraud on the federal government, by false claim or statement, can be assessed monetary penalties in addition to the penalties of the False Claims Act because

of a law called the Program Fraud Civil Remedies Act (referenced in this policy as "PFCRA"). Specifically, PFCRA penalties of \$5,000 per false claim or statement apply if a person or company submits a claim to the federal government that: the person or company knows or has reason to know is false, fictitious, or fraudulent; includes or is supported by written statements containing false, fictitious, or fraudulent information; includes or is supported by written statements that omit a material fact, which causes the statements to be false, fictitious, or fraudulent and the person submitting the statement has a duty to include the omitted fact; or is for payment of property or services that are not provided as claimed.

The \$5,000 penalty also applies if a person or company provides written back-up or materials relating to the claim in which the person or company asserts a material fact that is false, fictitious, or fraudulent; or omits a fact that the individual had a duty to include, the omission causes the statement to be false, fictitious, or fraudulent, and the statement contains a certification of accuracy.

Connecticut State Law

It is a crime in Connecticut to bill Medicaid or the general assistance program fraudulently. All employees, contractors, and agents of the Hospital must immediately report suspicion of any criminal activity occurring at the System, including criminal fraud, to the System Compliance and Privacy Officer.

Anyone who provides services to a state Medicaid beneficiary and seeks or accepts payment for unnecessary or improper services is subject to possible imprisonment and/or criminal fines under state law. Depending upon the amount of the fraudulent services involved, such offenses carry potentially significant penalties, with a maximum of 20 years in prison and a maximum fine of \$15,000.

Anyone who provides services to a recipient of Connecticut's general assistance program and seeks or accepts payment for unnecessary or improper services is also subject to civil and criminal penalties. Depending upon the amount of the fraudulent services involved, such offenses carry a minimum one-year prison sentence and a maximum of 20 years, as well as a maximum fine of \$15,000. Any person who defrauds Connecticut's general assistance program is also excluded from participating in the program for a minimum of one year.

Connecticut law protects employees who report suspected violations of state or federal law, including reports of criminal fraud. An employer may not discharge, discipline, or otherwise penalize an employee for reporting a violation of the law, or suspected violation, as long as the employee does not know the information being reported is false.

REFERENCES AND RELATED POLICIES

Relevant Connecticut Laws and Regulations

- Connecticut General Statutes § 4-61dd (Whistle blowing)
- Connecticut General Statutes § 17b-25a (Toll Free Vendor Fraud Telephone Hotline)
- Connecticut General Statutes § 17b-99 (Vendor Fraud)
- Connecticut General Statutes § 17b-102 (Financial Incentive for Reporting Vendor Fraud)

- Connecticut General Statutes § 17b-127 (General Assistance Fraud)
- Connecticut General Statutes § 31-51m (Protection of Employee Who Discloses Employer's Illegal Activities or Unethical Practices)
- Connecticut General Statutes § 31-51q (Liability of Employer for Discipline or Discharge of Employee on Account of Employee's Exercise of Certain Constitutional Rights)
- Connecticut General Statutes § 53-440 *et seq.* (Health Insurance Fraud)
- Connecticut General Statutes § 53a-118 *et seq.* (Larceny)
- Connecticut General Statutes § 53a-155 (Tampering with or Fabricating Physical Evidence)
- Connecticut General Statutes § 53a-157b (False Statement Intending to Mislead Public Servant)
- Connecticut General Statutes § 53a-290 *et seq.* (Vendor Fraud)
- Regulations of Connecticut State Agencies § 4-61dd-1 *et seq.* (Rules of Practice for Contested Case Proceedings under the Whistleblower Protection Act)
- Regulations of Connecticut State Agencies § 17-83k-1 *et seq.* (Administrative Sanctions)
- Regulations of Connecticut State Agencies § 17b-102-01 *et seq.* (Financial Incentive for Reporting Vendor Fraud and Requirements for Payment for Reporting Vendor Fraud)

Federal Law Cross References

- Section 6032 of the Deficit Reduction Act of 2005
- 31 U.S.C. §§ 3729-3733 (Federal False Claims Act)
- 31 U.S.C. §§ 3801-3812 (Administrative Remedies for False Claims and Statements)

Yale New Haven Health System Cross References

- Yale New Haven Health System Code of Conduct
- CC: R-23, Non-Retaliation and Non-Retribution for Reporting

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