Hartford HealthCare	**Subject:** **Preventing Fraud, Waste and Abuse Policy**	
Office of Compliance, Audit and Privacy **Policy Level: I** **Policy Number:** **HHC-C03**	**Original Date:** October 3, 2012 **Revision Date:** September 30, 2014 **Effective Date:** September 30, 2014	**Approved By:** Margaret Marchak Signature SVP, Chief Legal Officer Title **Approval Date:** September 30, 2014

Purpose:

To comply with Section 6032 of the Deficit Reduction Act of 2005 by informing members of the Hartford HealthCare (HHC) Community of the Federal False Claims Act, the Federal Program Fraud Civil Remedies Act and the Connecticut False Claims Act; providing general information regarding HHC's commitment to prevent, detect and report fraud, waste, and abuse; and explaining the rights of employees to be protected as whistleblowers.

Scope:

This Policy applies to all members of the HHC Community.

Policy:

The federal government and the State of Connecticut have enacted civil and criminal laws pertaining to the submission of false or fraudulent claims for payment or approval from a health care program. These false claims laws, which provide for criminal, civil, and administrative penalties, provide governmental authorities with authority to investigate and prosecute potentially fraudulent activities, and also provide anti-retaliation provisions for individuals who make good faith reports of fraud, waste, and abuse. HHC wants all employees, contractors and agents to be aware of the laws regarding fraud and abuse and false claims so that they can identify, report and work to resolve any issues.

Guidelines:

All members of the HHC Community are obligated to promptly report to OCAP (Office of Compliance, Audit and Privacy) any actual or suspected fraud, waste, or abuse in connection with the submission of claims for reimbursement to a state or federal health care program.

Reporting Potential Fraud, Waste, or Abuse

All members of the HHC Community must promptly report to OCAP any suspicion of fraud, waste, or abuse in connection with the submission of claims for reimbursement. Individuals who, in good faith, report issues related to fraud, waste, and abuse will be provided confidentiality to the extent possible under the law. If you wish to remain anonymous, you may call the ComplianceLine at **1-855-HHC-OCAP**, or go online to **HHC.OCAPComplianceLine.com**.

Reporting Any Other Concern

All members of the HHC Community are also encouraged to report to their supervisors any suspected violations of other policy or legal and regulatory concerns. If you feel that a concern is not satisfactorily resolved, other reporting contacts include your Human Resources representative, OCAP, the ComplianceLine, HHC Legal Services and any member of senior management.

For more information on the HHC Compliance Program, specific compliance policies or how to report any concerns, please contact OCAP directly or visit OCAP's webpage.

Legal Obligations:

Federal False Claims Act (FCA) (Civil 31 U.S.C. § 3729-3733 and Criminal 18 U.S.C. § 287)

The FCA imposes civil penalties on persons and companies who, for example, knowingly submit a false claim or statement to a federal health care program or otherwise conspire to defraud the government in order to receive payment. The term "knowingly" as defined in the FCA includes a person who has actual knowledge of the information, acts in deliberate ignorance of the truth or falsity of the information, or acts in reckless disregard of the truth or falsity of the information. No proof of specific intent to defraud may be required. Failure to report and return overpayments from Medicare and Medicaid within certain timeframes might also constitute a violation of the FCA. The FCA also protects people who make efforts to stop the suspected fraud. 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, in addition to the actual claim amount. Additional fines of up to three times the value of any charges may also be imposed. Criminal penalties for submitting false claims may include fines, imprisonment, or both.

The FCA promotes an environment of trust, encouraging employees and others to feel safe reporting, in good faith, a known or suspected false claim concern. 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 seek reinstatement, back pay, plus penalties, interest and other damages and fees if they are discharged, demoted, suspended, threatened, or harassed for such actions. Individuals who assist in an investigation, provide testimony, or participate in the government's handling of a false claim are protected under the law. The FCA provides that a person initiating a formal claim under the FCA (a qui tam or whistleblower lawsuit) may be entitled to a portion of funds recovered at the discretion of a federal court. The FCA's provisions are generally enforced by the U.S. Department of Justice.

Common examples of healthcare fraud are:

- Billing for services not furnished or medically necessary.
- Billing for equipment and supplies never used or excessively used in patient care.
- Upcoding (billing a higher level of service than performed or necessary.
- Duplicate billing – billing separately for services that should be bundled together at a lower rate
- Misrepresenting a diagnosis or falsifying documentation to justify payment.
- Waiving deductibles and co-pays in an illegal manner.
- Billing for services by personnel who did not meet standards, e.g. qualifications, licensure, education or supervision.

Federal Program Fraud Civil Remedies Act (31 U.S.C. § 3801-3812)

Persons or companies that present or cause to be presented a false claim or statement that the person knows or has reason to know is false, fictitious or fraudulent, can be assessed monetary penalties in addition to the penalties of the FCA according to a law called the Program Fraud Civil Remedies Act. Specifically, these penalties may include $5,000 per false claim or statement and an assessment of not more than twice the amount of the false claim. The term "knows or has reason to know" is defined in the Act as a person who has actual knowledge of the information, acts in deliberate ignorance of the truth or falsity of the information, or acts in reckless disregard of the truth or falsity of the information. No proof of specific intent to defraud may be required.

Connecticut False Claims Act (CFCA) (Conn. Gen. Stat. § 17b-301a)

The CFCA is similar to the FCA and prohibits any individual or entity from knowingly presenting or causing to be presented a false or fraudulent claim

for payment or approval under the medical assistance programs administered by the Connecticut Department of Social Services or knowingly making or causing to be made a false statement in order to get such a claim approved, or knowingly concealing, avoiding, or decreasing any obligation to pay or transmit money or property to the state. Any individual or entity that violates this prohibition can be subjected to civil monetary penalties of $5,000 to $10,000 per violation as well as up to three times the damages sustained by the state as a result of the false claim. The CFCA permits private individuals to initiate civil actions and protects these individuals from workplace retaliation. 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 court. In addition, any employee, contractor or agent who is discharged, demoted, suspended, threatened, harassed or in any other manner discriminated against in the terms and conditions of employment because of lawful acts done in furtherance of an action under the CFCA, including investigation for, initiation of, testimony for or assistance in a CFCA matter, or efforts to stop a violation of the CFCA, is entitled to relief necessary to make the employee, contractor or agent whole as outlined in the CFCA.

Non-Retaliation

HHC will not retaliate against any person who lawfully attempts to stop or report fraudulent billing practices or violations of the FCA, CFCA or any other state or federal law regarding false or fraudulent claims or who assists in a government investigation or handling of a false claim.

Definitions:

For the purposes of this Policy, the following definitions shall apply:

HHC:
Hartford HealthCare Corporation and any and all subsidiaries and joint ventures in which Hartford HealthCare or a subsidiary of Hartford HealthCare Corporation has a majority interest

HHC Community: Includes all (1) employees, including executive leadership, volunteers and trainees, (2) contractors, including medical directors, and section, department and division chiefs, and (3) agents, including members of the board of directors and board delegated committees and officers, of HHC.

State and Federal Health Care Programs: Includes, without limitation, Medicare, Medicaid, Children's Health Insurance Program (CHIP) and the Veterans health care program (TRICARE).

Miscellaneous:

This policy may be revised, supplemented, or rescinded at any time as HHC deems appropriate in its sole and absolute discretion, without prior notice. This policy (and any other policy) does not constitute a contract of employment and does not in any way limit or modify employees' at-will employment status.

Related Policies:
Code of Conduct
HHC-C04 Non-Retaliation Policy
HHC-C13 ComplianceLine Response Policy