



STATE OF CONNECTICUT
 Department of Mental Health & Addiction Services



COMMISSIONER'S POLICY STATEMENT AND IMPLEMENTING PROCEDURES

SUBJECT	Compliance: Prevention of Fraud, Waste and Abuse Policy of the Department of Mental Health and Addiction Services Informing Employees, Contractors and Agents of Details of the Federal False Claims Act, Protections for Reporting Individuals, Penalties for Violations, and Relevant State Laws
P & P NUMBER	Chapter 3.5
APPROVED	Miriam Delphin-Rittmon, Commissioner Date: 10/15/2015
EFFECTIVE DATE	October 15, 2015 <i>Miriam Delphin-Rittmon</i>
REVISED	8/6/2010, 6/19/2007
REFERENCES	Section 6032 of the Deficit Reduction Act of 2005 31 U.S.C. §§ 3729-3733 31 U.S.C. §§ 3801-3812 CT General Statute Sec. 31-51m CT General Statute Sec. 31-51q CT General Statute Sec. 53a-290 et seq. CT General Statute Sec. 17b-127 CT General Statute Sec. 53-440 et seq. CT General Statute Sec. 53a-118 et seq. CT General Statute Sec. 53a-155 CT General Statute Sec. 53a-157b CT General Statute Sec. 17b-25a CT General Statute Sec. 17b-99 CT General Statute Sec. 17b-102 CT General Statute Sec. 4-61dd Regs. CT State Agencies Sec. 17-83k-1 et seq. Regs. CT State Agencies Sec. 17b-102-01 et seq. Regs. CT State Agencies Sec. 4-61dd-1 et seq.
FORMS AND ATTACHMENTS	

STATEMENT OF PURPOSE

The purpose of this policy is to inform employees, contractors and agents of the Department of Mental Health and Addiction Services (DMHAS) of the federal False Claims Act (referenced in this policy as "FCA"), and to provide general information regarding DMHAS efforts to combat fraud, waste, and abuse in the healthcare system, 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 DMHAS must immediately report to the facility's compliance officer, any suspicion of fraud, waste, or abuse in connection with the business of DMHAS. DMHAS engages in specific compliance efforts to detect and prevent fraud, waste, and abuse, such as new employee orientation, OIG federal program exclusion screening, clinical education and training with medical records documentation and billing protocol as well as other pertinent state and federal laws.

If you would like more information on DMHAS compliance program or policies, or on how to report any concerns, please contact your supervisor, Human Resources and/or your Facility Compliance Officer.

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 report suspected fraud.

The FCA is not confined to healthcare claims, but extends to any payment requested of the federal government. The FCA applies to billing and claims sent from DMHAS to any government payor program, including Medicare and Medicaid.

It is the policy of DMHAS that an employee, contractor, or agent of DMHAS who 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. DMHAS fully supports that goal. Any person who lawfully 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 DMHAS for making such a report. 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 money 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 DMHAS must immediately report suspicion of any criminal activity occurring at DMHAS, including criminal fraud, to the facility's compliance 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.