SAINT PETER'S UNIVERSITY HOSPITAL *Treating you better...for life.*	**Policy S-M25:** **Deficit Reduction Act – Employee Education About False Claims Recovery**

Policy & Procedure Manuals: Administration, Compliance & Human Resources	**Policy No.S-M25**				
Joint Commission Chapter/Section: N/A	**Effective Date:** November 1, 2011				
Other Regulation(s): Cited within policy	**Publication Status:**	☐	New	☒	Revised
Source (i.e. author(s) or committee): Angela Melillo, VP Compliance	**Replaces Policy: S-M25 Employee Education About False Claims Recovery Policy and Supplement to P&P M-25**				
Cross-Referenced Policy/Policies: Corporate Compliance Plan; Code and Standards of Business Conduct; P&P Manual Policies M-22: Corporate Compliance; M-23: Conscientious Employee Protection Act; M-24: JCAHO Reporting; M-25: False Claims; Employee Compliance Responsibilities CCHR003; Internal Reporting of Potential Compliance Concerns CC-002; Compliance Hotline CC-004; Conflict of Interest HCSCC46					

BACKGROUND:
Saint Peter's University Hospital ("SPUH" or the "Hospital") is committed to full compliance with all applicable federal and state laws pertaining to false claims and the Deficit Reduction Act of 2005 (the "DRA").Among other things, the DRA requires health care providers, such as SPUH, that receive significant Medicaid funds to prepare and disseminate information to their employees and certain covered contractors and agents regarding state and federal false claims laws and the rights of employees to be protected as whistleblowers, as well as information concerning the internal policies and procedures that are in place for detecting and preventing fraud, waste and abuse

PURPOSE:
The purpose of this Policy is to ensure that employees and covered contractors and agents of the Hospital comprehend and understand how to perform their duties and responsibilities while adhering to applicable federal and state laws and regulations, and to provide protections against reprisal or retaliation for those who report in good faith actual or suspected wrongdoing. This policy incorporates guidance on the implementation of the DRA provisions pertaining to false claims issued by the Centers for Medicare & Medicaid Services ("CMS") and the New Jersey Division of Medical Assistance and Health Services ("NJDMAHS"), and is intended to supplement Saint Peter's Healthcare System ("the Healthcare System) Corporate Compliance Program and Healthcare System Policies and Procedures to detect and prevent fraud, waste and abuse, including SPUH's Policy and Procedure Manual ("P & P").

This Policy replaces SPUH Policy S-M25, Employee Education About False Claims Recovery Policy and Supplement to P& P M-25, effective May 1, 2008.

POLICY:
Quality, honesty and integrity are important values to all who are associated with SPUH. SPUH strives to ensure that all billings for patient care services and other transactions are properly documented and submitted in accordance with all applicable regulatory and third party payor requirements. SPUH has implemented a Corporate Compliance Program to assist the achievement of health care billing and coding compliance. SPUH can achieve success with its health care billing and coding compliance if all employees and covered contractors and agents of the Hospital perform their duties and responsibilities correctly and take initiative to ensure a culture of compliance.

DEFINITIONS:
For purposes of this Policy, a "contractor" or "agent" of the Hospital includes any contractor, subcontractor, agent or other person which or who, on behalf of SPUH, furnishes or otherwise authorizes the furnishing of Medicaid health care items or services, performs billing or coding functions, or is involved in the monitoring of health care provided by the Hospital (sometimes collectively referred to in this Policy as "covered contractors and agents"). The foregoing definition is intended to be consistent with the definition of covered contractors and agents that has been announced by CMS in its communications on the requirements of the DRA.

POLICY & PROCEDURE:
Under the auspices of the Corporate Compliance Program, SPUH had adopted the following policies and procedures to prevent and detect fraud, waste and abuse:

Corporate Compliance Plan: The Saint Peter's Healthcare System ("SPHS" or "the System") Corporate Compliance Plan, adopted and implemented by SPUH, confirms a culture of open lines of communication, problem resolution and a strict non-retaliation policy to protect from any form of retaliation employees, agents, and contractors that report in good faith a potential compliance issue. The Corporate Compliance Plan creates the position of Vice President, Corporate Compliance Officer (the "CCO") and sets forth the duties of all employees, agents, and medical staff members of the Hospital, including individuals employed through contracted agencies, and the Board of Trustees (hereafter known collectively as "Hospital Representatives"), pertaining to the avoidance of false or inaccurate claims or statements.

Code and Standards of Business Conduct: Within the Corporate Compliance Plan is a Code of Business Conduct that states that all employees are required: to comply with all federal and state health care program laws, regulations and rules relating to their job responsibilities; to take great care to assure that all billings to a federal or state health care program are truthful and accurate, are supported by complete and accurate documentation, and conform to all federal and state laws, regulations and rules; to not knowingly present or cause to be presented any claims for payments that are false, fictitious or fraudulent; to be sufficiently knowledgeable about the legal aspects of their responsibilities and activities in order to be able to avoid inadvertent or negligent violations of federal or state health care program laws, rules and regulations; and, in matters relating to compliance with federal or state health care programs laws, regulations and rules, to conduct themselves in an ethical manner reflecting the values and mission of SPUH.

Auditing and Monitoring: To help detect billing errors and fraud, SPUH monitors and/or audits and reports the results of these monitors and/or audits to the Audit and Compliance Committee of the Board and to other parties, as appropriate. As a means of preventing billing errors and fraud, employees receive general orientation and continuing education regarding general compliance requirements. The Corporate Compliance Department distributes to affected areas pertinent monitoring and/or audit results.

Education: All SPUH employees are required to become and remain familiar, and to comply, with all aspects of the Hospital's Code of Business Conduct, which they receive at new hire orientation. SPUH employees also are expected to receive and abide by continuing education and training on compliance matters throughout the duration of their employment.

Distribution: SPUH will distribute this Policy to all Hospital officers, administrators, managers, and staff All employees will receive a copy of this Policy and will be advised of its availability on the Hospital's intranet website in the Policies and Procedure's Library under the Corporate Compliance Policy Manual. Managers will also receive an email advising them of this Policy; its distribution and the distribution of any subsequent revisions shall be an agenda item at the SPUH Manager's meeting.

Covered contractors and agents shall be mailed a letter advising them of this Policy, its location on the SPUH Internet site and, as required by the DRA, shall be asked to disseminate this information to their applicable employees and managers and to adopt this Policy in connection with their activities on behalf of SPUH,. Depending on the circumstances and where feasible, the Hospital's contracts with covered contractors and agents will reiterate the obligation of such covered contractors and agents to comply with applicable federal and State laws such as the DRA, and in so doing, to abide by this Policy.

Reporting: The Corporate Compliance Plan requires all Hospital Representatives to report violations of law and forbids retaliation for such reporting. Any person who retaliates against another person for making a good faith report is subject to corrective action. In the event that a Hospital Representative discovers a potential compliance concern that might lead to a violation of SPUH's Policies and Procedures or any federal or state law or regulation, she/he/it should do the following:

(a) Employees should report the problem to their immediate supervisor. If the report is made to a supervisor or upward through the chain of command, that person is then required to report the suspected violation to the Chief Compliance Officer ("CCO").

(b) Contractors, agents or an employee who feels s/he cannot inform her/his supervisor about the problem, should raise the matter further up the chain of command and/or bring it to the attention of the Vice President – Chief Compliance Officer (telephone number 732-745-8600 ext 5071) or email (compliancevp@saintpetersuh.com) or in person on MOB 1- Room 1130.

(c) Employees, contractors, and agents can call the Compliance Hotline at 1-888-491-3010. Although SPUH does not allow any form of retaliation against employees who report instances of noncompliance, employees may feel more comfortable reporting the situation anonymously. Therefore, employees, agents and contractors may report concerns or problems anonymously or in confidence via the Hotline, twenty-four hours per day, every day of the year.

(d) Employees shall be protected against retaliation for reporting in good faith both under Saint Peter's Healthcare System's policies and procedures and Federal and State law.

(e) However, Saint Peter's Healthcare System and Saint Peter's University Hospital retain the right to take appropriate action against an employee who has participated in a violation of Federal or State law or healthcare system or hospital policy.

(f) Employees should remember that failure to report and disclose or assist in an investigation of fraud and abuse is a breach of the employee's obligations to the Healthcare System/Hospital and may result in disciplinary action

(g) If an employee believes that SPHS/SPUH is not responding to his or her report within a reasonable period of time, the employee should bring these concerns about perceived inaction to the Chief Compliance Officer. If the employee believes that the CCO is not responding within a reasonable period of time, the employee should bring these concerns to the Chief Operating Officer or the Chairman of the Audit and Compliance Committee of the Board.

Investigation and Corrective Action: The CCO will promptly and thoroughly investigate all potential compliance matters reported in order to determine what if any corrective actions are necessary. Additional information may be requested in order to complete an investigation. Once the investigation is complete, the Healthcare System shall take necessary actions in order to correct, mitigate and/or report the false claim or report any other identified fraud, waste or abuse.

Detection and timely reporting of misconduct will help maintain the integrity of the organization and preserve its status as a reliable, honest and trustworthy healthcare provider. Furthermore, penalties and sanctions can be materially reduced by voluntary disclosures of violations of civil, criminal or administrative law in a timely manner.

OTHER POLICIES:
In addition to complying with this Policy, all employees and covered contractors and agents of the Hospital must also be familiar and comply with the following policies and procedures:

• Corporate Compliance Plan	• Code and Standards of Business Conduct
• Employee Compliance Responsibilities CCHR003	• P & P Manual Policy M-22: Corporate Compliance
• Internal Reporting of Potential Compliance Concerns CC-002	• P & P Manual Policy M-23: Conscientious Employee Protection Act
• Compliance Hotline CC-004	• P & P Manual Policy M-24: JCAHO Reporting
• Conflict of Interest HCSCC46	• P & P Manual Policy M-25: False Claims

Additional policies and procedures as posted and updated on SPUH's intranet website in Public Folders under the Compliance Program tab and its legacy system, SPUH's Intranet website Polices and Procedures tab – Corporate Compliance Policy Manual.

Copies of these policies and procedures may be obtained via SPUH's intranet website or by contacting the Hospital's CCO (telephone number 732-745-8600 ext 5071).

VIOLATIONS:
Violations of this Policy or any applicable federal or state law pertaining to false claims may be grounds for disciplinary action up to and including immediate termination of employment, as well as possible legal and/or criminal action.

APPLICABLE LAWS:
Below are summaries of certain statutes that provide liability for false claims; these summaries are not indented to identify all applicable laws but rather to outline major provisions.

Federal False Claims Act (31 U.S.C. §§ 3729 – 3733)

The federal False Claims Act (the "FCA") imposes civil liability on any person or entity who:

- knowingly files a false or fraudulent claim for payments to Medicare, Medicaid or other federally funded health care program;
- knowingly uses a false record or statement to obtain payment on a false or fraudulent claim from Medicare, Medicaid or other federally funded health care program; or
- conspires to defraud Medicare, Medicaid or other federally funded health care program by attempting to have a false or fraudulent claim paid.

"Knowingly" means:
- actual knowledge that the information on the claim is false;
- acting in deliberate ignorance of whether the claim is true or false; or
- acting in reckless disregard of whether the claim is true or false.

A person or entity found liable under the federal False Claims Act presently is subject to a civil money penalty of between $5,500 and $11,000, as from time to time adjusted for inflation, plus three times the amount of damages that the government sustained because of the illegal act. In health care cases, the amount of damages sustained is the amount paid for each false claim that is filed.

Anyone may bring a *qui tam* action under the federal False Claims Act in the name of the United States in federal court. The case is initiated by filing the complaint and all available material evidence under seal with the federal court. The complaint remains under seal for at least 60 days and will not be served on the defendant. During this time, the government investigates the complaint. The government may, and often does, obtain additional investigation time by showing good cause. After expiration of the review and investigation period, the government may elect to pursue the case in its own name or decide not to pursue the case. If the government decides not to pursue the case, the person who filed the action has the right to continue with the case on his or her own.

If the government proceeds with the case, the person who filed the action will receive between 15 percent and 25 percent of any recovery, depending upon the contribution of that person to the prosecution of the case. If the government does not proceed with the case, the person who filed the action will be entitled to between 25 percent and 30 percent of any recovery, plus reasonable expenses and attorneys' fees and costs.

The federal False Claims Act states that any employee who is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment because of lawful actions taken in furtherance of a *qui tam* action is entitled to recover damages. He or she is entitled to "all relief necessary to make the employee whole," including reinstatement with the same seniority status, twice the amount of back pay (plus interest), and compensation for any other damages the employee suffered as a result of the discrimination. The employee also can be awarded litigation costs and reasonable attorneys' fees.

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

The Program Fraud and Civil Remedies Act (the "PFCRA") creates administrative remedies for making false claims and false statements. These penalties are separate from and in addition to any liability that may be imposed under the Federal False Claims Act.

The PFCRA imposes liability on people or entities who file a claim that they know or have reason to know:

- is false, fictitious, or fraudulent;
- includes or is supported by any written statement that contains false, fictitious, or fraudulent information;
- includes or is supported by a written statement that omits a material fact, which causes the statement to be false, fictitious, or fraudulent, and the person or entity submitting the statement has a duty to include the omitted fact; or
- is for payment for property or services not provided as claimed.

A violation of this section of the PFCRA is punishable by a $5,500 civil penalty for each wrongfully filed claim, plus an assessment of twice the amount of any unlawful claim that has been paid.

In addition, a person or entity violates the PFCRA if they submit a written statement which they know or should know:

- asserts a material fact that is false, fictitious or fraudulent; or
- omits a material fact that they had a duty to include, the omission caused the statement to be false, fictitious, or fraudulent, and the statement contained a certification of accuracy.

A violation of this section of the PFCRA carries a civil penalty of up to $5,500 in addition to any other remedy allowed under other laws.

New Jersey False Claims Laws

Both the New Jersey Medical Assistance and Health Services Act (N.J.S.A. 30:4D-1 et seq.) and New Jersey's Health Care Claims Fraud laws provide both criminal penalties and civil remedies for false health care claims.

Criminal Penalties

Under the Medical Assistance and Health Services Act (N.J.S.A. 30:4D-17 subsections a through d), any person or provider who willfully obtains benefits to which he/she is not entitled, or in a greater amount than that entitled, is guilty of a high misdemeanor and shall be fined up to $10,000 or shall be sentenced to up to three (3) years imprisonment or both.

Additionally, any provider, person, or entity who

1) knowingly or willfully makes, or causes to be made, a false claim; or
2) knowingly and willfully makes, or causes to be made, a false statement for use in determining a benefit or payment; or
3) conceals or fails to disclose an event that either affects his/her right to a benefit or payment or affects the right of a person, provider or entity to a benefit or payment with an intent to fraudulently secure such benefit or payment not authorized, or in a greater amount than that which is authorized; or
4) knowingly and willfully converts benefits or payments, or any part thereof, for the use or benefit of any person, provider or entity other than that which received the benefit or payment

is guilty of a high misdemeanor and shall be fined up to $10,000, for the first and each subsequent offense, or shall be sentenced to up to three (3) years imprisonment or both.

The law also provides that any person, provider or entity who solicits, offers or receives any kickback, rebate or bribe in connection with items or services for which payment is either made, reported for purpose of payment, or received pursuant to the Medical Assistance and Health Services Act is guilty of a high misdemeanor and shall be fined up to $10,000 or shall be sentenced to up to three (3) years imprisonment or both.

Furthermore, the law provides that whoever knowingly and willfully makes, or causes to be made, any false statement or representation of a material fact with respect to the conditions or operations of any institution or facility in order that such institution or facility may qualify either upon initial certification or recertification as a hospital, skilled nursing facility, intermediate care facility, or health agency, thereby entitling them to receive payments, shall be guilty of a high misdemeanor and shall be fined up to $3,000.00 or shall be sentenced to up to three (3) years imprisonment or both.

Pursuant to the criminal code, N.J.S.A. 2C:12-4.2 sets forth the following definitions:

- "Health care claims fraud" means making, or causing to be made, a false, fictitious, fraudulent, or misleading statement of material fact in, or omitting a material fact from, or causing a material fact to be omitted from, any record, bill, claim or other document, in writing, electronically or in any other form, that a person attempts to submit, submits, causes to be submitted, or attempts to cause to be submitted for payment or reimbursement for health care services.

- "Practitioner" means a person licensed in New Jersey to practice medicine and surgery, chiropractic, podiatric medicine, dentistry, optometry, psychology, pharmacy, nursing, physical therapy, or law; any other person licensed, registered or certified by any State agency to practice a profession or occupation in this State or any person similarly licensed, registered, or certified in another jurisdiction.

N.J.S.A. 2C:12-4.3 provides that a practitioner is guilty of a 2nd degree crime if he/she knowingly commits health care claims fraud in the course of providing professional services. A practitioner is guilty of a 3rd degree crime if he/she recklessly commits health care claims fraud in the course of providing professional services. In addition to all the other criminal penalties allowed by law, practitioners convicted of these crimes may also be subject to a fine of up to five (5) times the pecuniary benefit obtained or sought.

N.J.S.A. 2C:12-4.3 also provides that a person, who is not a practitioner as defined by N.J.S.A. 2C:12-4.2, is guilty of a 2nd degree crime if he/she knowingly commits health care claims fraud. However, if a non-practitioner knowingly commits five (5) or more acts of health care claims fraud and the aggregate pecuniary benefit obtained or sought is at least $1000, that person is guilty of a 2nd degree crime. Additionally, a non-practitioner who recklessly commits health care claims fraud is guilty of a 4th degree crime. In addition to all the other criminal penalties allowed by law, non-practitioners convicted these crimes may also be subject to a fine of up to five (5) times the pecuniary benefit obtained or sought.

For the purposes of criminal prosecution, N.J.S.A. 2C:12-4.3 provides that a person acts recklessly when he/she consciously disregards a substantial and unjustifiable risk. The risk must be of such a nature and degree that, considering the nature and purpose of the actor's conduct and the circumstances known to him/her, its disregard involves a gross deviation from the standard of conduct that a reasonable person would observe in the actor's situation.

N.J.S.A. 2C:51-5 provides following additional penalties for practitioners who commit health care claims fraud pursuant to N.J.S.A. 2C:21-4.3:

- A practitioner convicted of the 2nd degree crime shall forfeit his/her license and is forever barred from the practice of the profession. However, if the court finds that such forfeiture would be a serious injustice which overrides the need to deter such conduct by others, the court shall determine the appropriate period of license suspension which shall be not less than one (1) year.
- A practitioner convicted of the 3rd degree crime shall have his/her license suspended and is barred from the practice of the profession for at least one (1) year.

- A practitioner who receives a second conviction of the 3rd degree crime shall forfeit his/her license and is forever barred from the practice of the profession.

Civil Remedies

Under the Medical Assistance and Health Services Act (N.J.S.A. 30:4D-17 subsections e through i), a person or legal entity who violates subsections (a) through (d) shall, in addition to any other penalties provided by law, be liable to civil penalties of:

1) payment of interest on the amount of the excess benefits or payments at the maximum legal rate in effect on the date the payment was made to said person or other entity for the period from the date upon which payment was made to the date upon which repayment is made to the State,
2) payment of an amount not to exceed three-fold the amount of such excess benefits or payments, and
3) payment in the sum not less than and not more than the civil penalty allowed under the federal FCA, as from time to time amended (presently between $5,500 and $11,000), for each excessive claim for assistance, benefits or payments.

Additionally, any person or legal entity, other than an individual recipient of medical services, who, without intent to violate this act, obtains medical assistance or other benefits or payments under this act in excess of the amount to which he/she/it is entitled, shall be liable to a civil penalty of payment of interest on the amount of the excess benefits or payments at the maximum legal rate in effect on the date the benefit or payment was made to said person or legal entity for the period from September 15, 1976 or the date upon which payment was made, whichever is later, to the date upon which repayment is made to the State.

All penalties and interests which apply pursuant to the law shall be recovered in an administrative procedure. Upon the failure of a person or legal entity to comply after service of an order directing payment of any amount found to be due, a docketed judgment may be entered indicating that such person or legal entity is indebted to the State for the payment of such amount.

The Medical Assistance and Health Services Act (N.J.S.A. 30:4D-17.1) also provides that any person, provider or legal entity may be suspended from the Medicaid program for good cause. Furthermore, medical assistance benefits may be terminated or otherwise restricted to any eligible recipient thereof for good cause.

New Jersey False Claims Act

Under the New Jersey False Claims Act (N.J.S.A. 2A:32C-1 et seq.), which was enacted into law in January 2008 in accordance with the provisions of the DRA, any person who commits any of the following acts shall be held jointly and severally liable to the State for a civil penalty of not less than and not more than the civil penalty allowed under the federal FCA, as from time to time amended (presently between $5,500 and $11,000) plus three times the amount of damages which the State sustains, for each false or fraudulent claim:

- knowingly presenting or causing to be presented a false or fraudulent claim for payment or approval to an employee, officer or agent of the State, or to any contractor, grantee or other recipient of State funds;
- knowingly making, using or causing to be made or used a false record or statement to get a false or fraudulent claim paid or approved by the State;
- conspiring to defraud the State by getting a false or fraudulent claim allowed or paid by the State;
- having possession, custody or control of public property or money used or to be used by the State and intending to defraud the entity or willfully to conceal the property, delivering or causing to be delivered less property than the amount for which the person receives a certificate or receipt;
- being authorized to make or deliver a document certifying receipt of property used or to be used by the State and knowingly making or delivering a receipt without completely knowing that the information on the receipt is true;
- knowingly buying, or receiving as a pledge of an obligation or debt, public property from any person who lawfully may not sell or pledge the property; or
- knowingly making, using, or causing to be made or used a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the State.

For purposes of the New Jersey False Claims Act, the term "knowingly" has essentially the same meaning as under the federal FCA (i.e., includes actual knowledge, deliberate ignorance or reckless disregard of the truth or falsity of information). Only acts occurring by innocent mistake or as a result of mere negligence are excepted from liability under the New Jersey False Claims Act.

Any violation of the New Jersey False Claims Act also establishes independent liability under N.J.S.A. 30:4D-17(e), which as referenced above, provides that a person or legal entity who violates certain legal authorities (including the New Jersey False Claims Act), shall, in addition to any other penalties provided by law, be liable to civil penalties of:

1. payment of interest on the amount of the excess benefits or payments at the maximum legal rate in effect on the date the payment was made to said person or other entity for the period from the date upon which payment was made to the date upon which repayment is made to the State,
2. payment of an amount not to exceed three-fold the amount of such excess benefits or payments, and
3. payment in the sum not less than and not more than the civil penalty allowed under the federal FCA, as from time to time amended (presently between $5,500 and $11,000), of $2,000.00 for each excessive claim for assistance, benefits or payments.

Similar to the *qui tam* provisions under the federal FCA, any person may bring a civil action for a violation of the New Jersey False Claims Act in the name of the State of New Jersey. As with cases filed under the federal FCA, complaints filed under the New Jersey False Claims Act initially remain under seal for at least 60 days, during which time the Attorney General's Office will investigate the matter and determine whether or not it desires to intervene in the case. The Attorney General's Office may obtain additional investigation time by showing good cause. If the Attorney General's Office decides to intervene in the case, it will assume primary responsibility for prosecuting the action. If, however, the Attorney General's Office decides not to intervene in the case, then the person who initially filed the complaint has the right to conduct the action.

If the Attorney General's Office proceeds with the case, the person who initially filed the complaint generally will receive between 15 percent and 25 percent of any recovery, depending upon the extent of that person's contribution to the prosecution of the case, plus reasonable expenses and attorneys' fees and costs. If the Attorney General's Office proceeds with the case, that Office will receive 10 percent of any recovery for deposit into a newly-established "False Claims Prosecution Fund" supporting ongoing investigation and prosecution of false claims, plus reasonable attorneys' fees, expenses and costs. If the Attorney General's Office declines to proceed with the case and the person who initially filed the complaint decides to conduct the action in the absence of such governmental intervention, that person generally will receive between 25 percent and 30 percent of any recovery, plus reasonable expenses and attorneys' fees and costs.

Similar to the federal FCA, the New Jersey False Claims Act also contains provisions that specifically protect employees from retaliatory action by employers (e.g., discharge, demotion, suspension, threats, harassment, denial of promotion, discrimination in the terms and conditions of employment, etc.) because of lawful acts done by the employee on behalf of the employee or others in disclosing information to a State or law enforcement agency or in furthering a false claims action, including investigation for, initiation of, testimony for, or assistance in an action filed or to be filed under the New Jersey False Claims Act. An employer who violates these provisions will be held liable for all relief necessary to make the employee whole, including reinstatement with the same seniority status, two times the amount of any applicable back pay plus interest, compensation for any special damage sustained as a result of the employer's wrongful actions against the employee, and where appropriate, punitive damages. The employee also can be awarded litigation costs and reasonable attorneys' fees.

Conscientious Employee Protection Act

SPUH prohibits any retaliatory action against an employee who acts pursuant to the Conscientious Employee Protection Act (N.J.S.A. 34:19-1 et seq.) or CEPA. CEPA prohibits an employer from taking any retaliatory action against an employee because the employee does any of the following:

a. Discloses, or threatens to disclose, to a supervisor or to a public body an activity, policy or practice of the employer or another employer, with whom there is a business relationship, that the employee reasonably believes is in violation of a law, or a rule or regulation issued under the law, or, in the case of

an employee who is a licensed or certified health care professional, reasonably believes constitutes improper quality of patient care;

b. Provides information to, or testifies before, any public body conducting an investigation, hearing or inquiry into any violation of law, or a rule or regulation issued under the law by the employer or another employer, with whom there is a business relationship, or, in the case of an employee who is a licensed or certified health care professional, provides information to, or testifies before, any public body conducting an investigation, hearing or inquiry into quality of patient care; or

c. Objects to, or refuses to participate in, any activity, policy or practice which the employee reasonably believes:

i) is in violation of a law, or a rule or regulation issued under the law or, if the employee is a licensed or certified health care professional, constitutes improper quality of patient care;
ii) is fraudulent or criminal; or
iii) is incompatible with a clear mandate of public policy concerning the public health, safety or welfare or protection of the environment.

Upon a violation of the CEPA provisions, an aggrieved and/or former employee may, within one year, bring suit in any court with jurisdiction. All remedies available in common law tort actions shall be available to prevailing plaintiffs, in addition to any legal or equitable relief provided by CEPA or any other applicable law.

Where appropriate, the court shall order:

1. An injunction to restrain any CEPA violation which is occurring at the time that the court issues its order;
2. The reinstatement of the employee to the same, or an equivalent, position he/she held before the retaliatory action;
3. The reinstatement of full fringe benefits and seniority rights;
4. Compensation for all lost wages, benefits and other remuneration; and
5. Payment by the employer for all reasonable costs and attorney's fees incurred by the employee.

Additionally, a court or jury may order:

1. the imposition of a civil fine up to $10,000 for the first violation and up to $20,000 for each subsequent violation;
2. punitive damages; or
3. both a fine and punitive damages.

SPUH has designated the Corporate Compliance Office to answer your questions or provide additional information regarding your rights and responsibilities under CEPA.

Compliance with these policies is a required condition of employment or continued engagement with the Healthcare System. Violations of these policies should be reported to the VP-Chief Compliance Officer. The Chief Compliance Officer may be contacted by in person (MOB 1 – Room 1130); by telephone (732-745-8600 ext.5071); secure email compliancevp@saintpetersuh.com ; in writing or through the Compliance Hotline (1-888-491-3010)	
REFER INQUIRIES TO (NAME/TITLE) Angela M Melillo V.P. – Chief Compliance Officer	732-745-8600 ext 5071
APPROVED BY (SIGNATURE) Angela M. Melillo	Vice President, Chief Compliance Officer