AtlantiCare

Policy & Procedure	ID No.	3119
Subject: **Education Concerning False Claims Liability, Anti-Retaliation Protections, and Detecting and Responding to Fraud**	*Category:*	**Leadership**
Facility Scope: **AtlantiCare Health System**	*Department:*	**General**

Purpose: AtlantiCare Health System is committed to full compliance with all applicable federal and state laws pertaining to false claims and the Deficit Reduction Act of 2005. This Policy incorporates the guidelines issued by the Centers for Medicare & Medicare Services and is a supplement to the employee handbook and the Corporate Compliance Program. This Policy shall ensure that employees and covered contractors and agents of AHS understand how to perform their duties and responsibilities while adhering to applicable federal and state laws and regulations and how those who report actual or suspected wrongdoing are protected under such laws. The Corporate Compliance Program is the process for identifying and reducing risk and improving internal controls. This Policy is intended to provide all employees, management and covered contractors and agents of AHS with information regarding its policies and procedures to detect and prevent fraud, waste and abuse.

Scope: This Policy applies to all directors, officers, administrators, managers, staff, employees, and covered contractors and agents of AtlantiCare Health System ("AHS").

Definitions: For purposes of this policy, a covered "contractor" or "agent" includes any contractor, subcontractor, agent or other person which or who, on behalf of AtlantiCare Health System, 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 AHS (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 the Centers for Medicare and Medicaid Services in its recent communications on the requirements of the DRA.

Policy: It is the policy of AtlantiCare Health System to obey all federal and state laws, to implement and enforce procedures to detect and prevent fraud, waste and abuse regarding payments to AHS from federal or state healthcare programs, and to provide protections for those who report actual or suspected wrongdoing. AHS is committed to ensuring that all billings for patient services and other transactions are properly documented and authorized by management. AHS can achieve success with its healthcare billing compliance if all employees and covered contractors and agents perform their duties and responsibilities correctly and take initiative to ensure a culture of compliance.

Distribution: This Policy shall be distributed to all current Board members, officers, administrators, managers, staff, employees, and covered contractors and agents of AtlantiCare Health System. The Policy will be emailed to all managers who will distribute it to staff and post it within their departments. The Policy will be posted on AHS' intranet policy and procedure site. Information about this Policy will be provided to all new hires at orientation and also included in each AHS business unit Employee Handbook.

Effective: 2/6/2007	Reviewed: 8/21/13; 9/22/15	Revised: 7/1/2008, 11/15/18	Review Cycle: Triennial
Owner: Timothy Koob, Corp. Compliance Officer/Director Internal Auditing	Source: Federal False Claims Act (31 U.S.C Section 3729 – 3733); Federal Program Fraud Civil Remedies Act of 1986 (31 U.S.C Sections 3801 3812); Federal Deficit Reduction Act of 2005; NJ Medical Assistance and Health Services Act (N.J.S.A. 30:4D-1 et seq.); NJ Conscientious Employee Protection Act (N.J.S.A. 34:19-1 et seq.)		Authorized By: Lori Herndon, CEO & President; Audit Committee

Policies & Procedures for Detecting and Preventing Fraud:

- Corporate Compliance Program: The Corporate Compliance Program establishes the foundation for AHS' policies and procedures related to detecting and preventing fraud, waste and abuse. The policies and procedures contained in the Corporate Compliance Program document serve to reiterate and augment the message of compliance communicated by the *AHS Code of Business Ethics and Corporate Compliance* (Code of Conduct). The Compliance Program document also contains specific corporate policies and procedures which serve to provide a framework and mechanism by which AHS can implement, monitor and improve current, proactive compliance initiatives. Questions concerning AHS' Corporate Compliance Program can be directed to the Corporate Compliance Department or Legal Department.

- AHS Code of Business Ethics and Corporate Compliance (Code of Conduct): The Code of Conduct outlines the standards of professional conduct for all Board members, corporate officers, managers and employees of all of the companies that comprise AHS.

- Orientation: As part of new hire orientation, all employees will be provided copies of this Policy. DRA requirements will be emphasized as part of compliance orientation.

- Education: All AHS employees are required to become and remain familiar, and to comply, with all aspects of the Code of Conduct. AHS employees also are expected to receive and abide by continuing education and training on compliance matters throughout the duration of their employment. Compliance training will be included in AHS' Learning Management System (HealthStream).

- Reporting: AHS takes all reports of non-compliance seriously and addresses them completely and expeditiously. The purpose of voluntary disclosure is to provide a mechanism with which employees, vendors, patients, contractors, and agents may report any matter that may be unprofessional, unethical, illegal, or, potentially, an issue of non-compliance, without fear of retribution. Reports of problems/concerns may be made through AHS' Compliance/Privacy Phone Line (externally at (609) 407-7788 or internally at 3-7788 or online at MyComplianceReport.com (access code ATC)). Strict confidentiality protections are in place. Reports can also be made directly to the Corporate Compliance Department or Legal Department or AHS management.

- Non-Retaliation: The Corporate Compliance Program requires all employees and covered contractors and agents to report violations of law and forbids retaliation for such reporting.

- Investigation and Corrective Action: AHS will promptly and thoroughly investigate all potential compliance matters reported in order to determine what if any corrective actions are necessary. Detection and timely reporting of misconduct will help maintain the integrity of AHS 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.

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: Set forth below are summaries of certain statutes that provide liability for false claims and statements. These summaries are not intended to identify all applicable laws but rather to outline some of the major statutory provisions as required by the Deficit Reduction Act of 2005.

FEDERAL FALSE CLAIMS LAWS

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

The Federal False Claims Act (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
- conspire 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 is subject to a significant civil money penalty 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 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 (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 $5,000 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 $5,000 in addition to any other remedy allowed under other laws.

NEW JERSEY FALSE CLAIMS LAWS

Effective March 13, 2008, an Act established the "New Jersey False Claims Act", supplementing Title 2A of the New Jersey Statutes and amending P.L. 1968, c.413. The Act has three main parts: (1) authorizes the NJ Attorney General and whistleblowers to initiate false claims litigation similar to what is authorized under the Federal False Claims Act, and has

similar whistleblower protections, (2) amends the NJ Medicaid statute to make violations of the NJ False Claims Act give rise to liability under NJS 30:4D-17(e), and (3) amends the NJ Medicaid statute to increase the $2,000 per false claim penalties currently under NJS 30:4D-17(e)(3) to the same level provided for under the Federal False Claim Act.

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 of not less than and more than the civil penalty allowed under the Federal False Claims Act as it may be adjusted for inflation pursuant to the Federal Civil Penalties Inflation Adjustment Act of 1990, 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.

Conscientious Employee Protection Act

AHS 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:
   (1) 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;
   (2) is fraudulent or criminal; or

(3) 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.

Role of False Claims Laws: The laws described in this policy create a comprehensive scheme for controlling waste, fraud and abuse in federal and state health care programs by giving appropriate governmental agencies the authority to seek out, investigate and prosecute violations. Enforcement activities are pursued in three available forums -- criminal, civil and administrative. This provides a broad spectrum of remedies to battle this problem.
Anti-retaliation protections for individuals who make good faith reports of waste, fraud and abuse encourage reporting and provide broader opportunities to prosecute violators. Statutory provisions, such as the anti-retaliation provisions of the Civil False Claims Act, create reasonable incentives for this purpose. Employment protections create a level of security employees need to assist with the prosecution of these cases.

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DEFINITIONS:

AtlantiCare: AtlantiCare is defined as any and all affiliated companies of the AtlantiCare Health System, including its joint ventures operating under the AtlantiCare trademark, and captive professional services corporations such as AtlantiCare Physicians Group.

AtlantiCare affiliate: AtlantiCare affiliate is defined as an organization associated with another AtlantiCare organization as a subordinate, subsidiary, or member.