

HUNTERDON HEALTHCARE SYSTEM
ADMINISTRATIVE POLICY AND PROCEDURE MANUAL

Subject: Corporate Compliance Program - Deficit Reduction Act of 2005	No. HHS-109	Date: 3/2007
	Page: 1	Of: 8

Policy:

It is the policy of the Hunterdon Healthcare System (HHS) to be in compliance with all federal, state and local laws and regulations, to put into practice procedures designed to detect and prevent fraud and abuse, and to maintain policies to protect those who report, in good faith, any concerns of actual or suspected wrongdoing.

Purpose:

To be in compliance with the provisions of Section 6032 of the Deficit Reduction Act of 2005 by providing information to all employees, contractors and agents of the Hunterdon Healthcare System about federal and state false claims laws, the protections provided to those who report, in good faith, any concern or suspicion of violation under applicable laws or regulations, and HHS' policies and procedures for detecting and preventing fraud. A "contractor" or "agent" includes any contractor, subcontractor, agent, or other person which or who, on behalf of HHS, furnishes, or otherwise authorizes the furnishing of Medicaid health care items or services, performs billing or coding functions, or is involved in monitoring of health care provided by HHS.

Background:

On February 8, 2006 The Deficit Reduction Act of 2005 ("the Act") was signed into law. Section 6032 of the Act requires entities like HHS that receive more than \$5 million of Medicaid funds establish written policies for all employees, contractors or agents to provide information about state and federal false claims laws, whistleblower protections and its policies for fraud detection.

Explanation of Federal and State False Claims Laws:

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

The federal False Claims Act allows for civil penalties to be imposed on any person or entity who:

- Knowingly submits a false or fraudulent claim to a federally funded health care program (i.e. Medicare) for payment.
- Attempts to obtain or does obtain payment from a federally funded health care program by purposely utilizing false or fraudulent information, records or statements.
- Conspiring to defraud a federally funded health care program by attempting to have a -false or fraudulent claim paid.

"Knowingly" is defined as actual knowledge that information on a claim is false, acting in deliberate ignorance of claim accuracy, or reckless disregard for claim accuracy.

HUNTERDON HEALTHCARE SYSTEM
ADMINISTRATIVE POLICY AND PROCEDURE MANUAL

Subject: Corporate Compliance Program - Deficit Reduction Act of 2005	No. HHS-109	Date: 3/2007
	Page: 2	Of: 8

Liabilities under the False Claims Act include monetary penalties of \$5,500 to \$11,000 plus 3 times the amount of damages for each false claim filed.

Anyone, including private citizens, may bring a *qui tam* action under the Federal False Claims Act in the name of the United States in federal court. The party bringing the case (the “qui tam relator”) is commonly known as a “whistleblower.” 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 whistleblower has the right to continue with the case on his or her own.

If the government proceeds with the case, the whistleblower 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 whistleblower will be entitled to between 25 percent and 30 percent of any recovery, plus reasonable expenses and attorneys’ fees and costs.

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

The Program Fraud and Civil Remedies Act (“PFCRA”) provides for administrative remedies for submitting false claims or filing false statements, which are separate from and in addition to any liability under the Federal False Claims Act. The PFCRA imposes liability against those 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 any written statement that omits a material fact, which causes the statement to be false, fictitious, or fraudulent, and there exists a duty to include the omitted fact; or
- is for payment for property or services not provided as claimed.

These violations are punishable by a \$5,000 civil penalty for each wrongfully filed claim, plus 2 times the amount of damages for each false claim filed.

Additionally, it is a violation of the PFCRA for any person or entity to submit a written statement which they know or should know asserts a material fact that is false, fictitious, or fraudulent; or submits a statement that contained a certification of accuracy, which omits

HUNTERDON HEALTHCARE SYSTEM
ADMINISTRATIVE POLICY AND PROCEDURE MANUAL

Subject: Corporate Compliance Program - Deficit Reduction Act of 2005	No. HHS-109	Date: 3/2007
	Page: 3	Of: 8

any material fact that they had a duty to include and the omission caused the statement to be false, fictitious, or fraudulent. This violation carries a monetary penalty of \$5,000 in addition to any other remedy allowed under other laws.

3. New Jersey Health Care Claims Fraud Act (N.J.S.A. 2C:21-4.2 to 2C:21-4.3 and 2C:51-5)

The New Jersey Health Care Claims Fraud Act makes health care claims fraud a criminal offense and provides for forfeiture of professional licenses (*e.g.*, medical, dental, chiropractic, nursing) in certain instances in which a “practitioner” commits health care claims fraud. Practitioners are those who are licensed to practice certain named professions (*e.g.*, medicine, dentistry, chiropractic, nursing). The law also extends to non-practitioners who commit health care claims fraud (*e.g.*, hospital billing personnel).

The law defines “health care claims fraud” broadly as:

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.

Liabilities under the NJHCCFA include fines of up to \$150,000 or five times the amount of damages for each false claim. Additionally, punishments can include prison terms of 5 to 10 years for a practitioner and the claim is submitted in the course of providing professional services; or 3 to 5 years for non-practitioners who file a false claim.

4. New Jersey Medical Assistance and Health Services Act (N.J.S.A. 30:4D-17(a)-(i), 7h, and 17.1a)

The New Jersey Medical Assistance and Health Services Act provides for civil and criminal penalties for fraud committed in connection with the New Jersey Medical Assistance (Medicaid) Program.

The Act allows for the imposition of a criminal penalty of up to \$10,000 or imprisonment for not more than 3 years or both:

- on any person who willfully obtain medical assistance benefits to which he is not entitled and on any provider who willfully receives medical assistance payments to which it is not entitled;

HUNTERDON HEALTHCARE SYSTEM
ADMINISTRATIVE POLICY AND PROCEDURE MANUAL

Subject: Corporate Compliance Program - Deficit Reduction Act of 2005	No. HHS-109	Date: 3/2007
	Page: 4	Of: 8

- on any person or entity who, with an intent to fraudulently secure benefits not authorized or in a greater amount than authorized,
- knowingly and willfully makes or causes to be made any statement or representation of a material fact in any cost study, claim form, or any document necessary to apply for or receive any benefit or payment under the Act;
- knowingly and willfully makes or causes to be made any false statement, written or oral, of a material fact for use in determining rights to benefit or payment under the Act; or
- conceals or fails to disclose the occurrence of an event which affects an initial or continued right to benefit or payment; and
- on any provider, person or entity who solicits, offers, or receives any kickback, rebate or bribe in connection with the furnishing of services for which payment is made under the Act or whose cost is reported to obtain benefits or payments under the Act, or the receipt of any benefit or payment under the Act.

Any person who knowingly and willfully converts benefits or payments received for the use and benefit of any provider or person to another use shall be liable for a criminal penalty of up to \$10,000 for the first and each subsequent offense or to imprisonment for not more than 3 years or both.

Any person who knowingly and willfully makes or causes to be made or induces or seeks to induce the making of any false statement or representation of a material fact with respect to the conditions or operations of any institution or facility in connection with certification or re-certification shall be liable for a criminal penalty of up to \$3,000 or imprisonment for not more than 1 year or both.

This statute also allows for the imposition of civil penalties including the payment of interest on the amount of excess benefits or payments made, the payment of up to three times the amount of excess benefits or payments made, and the payment in the amount of \$2,000 for each excessive claim for assistance, benefits or payments.

Providers are also subject to suspension, debarment or disqualification from participation in the Medical Assistance Program.

5. *NOTE: NJ has two additional pieces of legislation pending (S360 and A3428) as well as a proposed regulation from the Division of Medical Assistance and Health Services (38 N.J.R. 4358). Updates to this section shall be made as appropriate should any of these be passed by appropriate government officials.*

HUNTERDON HEALTHCARE SYSTEM
ADMINISTRATIVE POLICY AND PROCEDURE MANUAL

Subject: Corporate Compliance Program - Deficit Reduction Act of 2005	No. HHS-109	Date: 3/2007
	Page: 5	Of: 8

Explanation of Whistleblower Protections under Federal and State Laws:

Individuals within HHS who observe activities or behavior that may violate the law in some manner and who report their observations either to management or to government agencies are provided protections under certain laws.

1. Federal False Claims Act Protections are afforded to people who file *qui tam* (“whistleblower”) lawsuits under the Federal False Claims Act, which is discussed earlier in this policy. The Civil 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 attorney’s fees.
2. New Jersey’s Conscientious Employee Protection Act (N.J.S.A. 34:19-1 et seq.)

The New Jersey Conscientious Employee Protection Act prohibits retaliatory actions by employers against employees who, in good faith, disclose information to any supervisor or public body, that the employee reasonably believes is in violation of any law, regulation, statute, policy or procedure or is fraudulent or criminal.

The Act also protects the employee from retaliation for any objection or refusal to participate in any activity or practice that the employee reasonably believes is in violation of any law, regulation, statute, policy or procedure or is fraudulent or criminal.

Additionally, these protections extend to testimony given during any investigation, hearing or other inquiry.

3. HHS Non-Retaliation Policy

In accordance with HHS Administrative Policy HHS-101, no adverse action or retribution of any kind will be taken by HHS against any individual because he or she reports, in good faith, a suspected violation of the Code of Ethics, any federal or state regulation, any HHS policy, or other irregularity by any person.

HUNTERDON HEALTHCARE SYSTEM
ADMINISTRATIVE POLICY AND PROCEDURE MANUAL

Subject: Corporate Compliance Program - Deficit Reduction Act of 2005	No. HHS-109	Date: 3/2007
	Page: 6	Of: 8

HHS Policies and Procedures for Detecting and Preventing Fraud:

1. HHS has a comprehensive Corporate Compliance Program aimed at detection and prevention of fraud, waste and abuse. The organization's Corporate Compliance policies that are designed to detect and prevent fraud and abuse are as follows:
 - i. HHS-101 Corporate Compliance Program-Code of Ethics, including:
 1. *Hotline reporting information*
 2. *Non-Retaliation policy*
 - ii. HHS-102 Corporate Compliance Program-Duties of Compliance Officer
 - iii. HHS-104 Corporate Compliance Program-Training Program
 - iv. HHS-106 Corporate Compliance Program-Fraud and Abuse and Self-Referral Concerns
 - v. HHS-108 Corporate Compliance Program-Resolution of Corporate Compliance Complaints
1. All corporate compliance policies and procedures are available to all employees in written format in the Employee Reference Guide as well as through the Corporate Compliance Department and the HHS Intranet.
2. Education on this Policy and the above information is provided to all new hires during orientation. Education on this Policy will be provided to new contractors or agents as engaged.
3. All employees will receive refresher training on this information on an annual basis and as appropriate in the event of updates to this regulation.
4. All vendors and agents will receive all information as required by the Act.

Responsibilities:

1. The Corporate Compliance Department ensures that all required information and educational materials are complete, accurate and readily available to all employees, vendors and agents.
2. All employees are responsible for attending all required education sessions and completing any written and/or online educational requirements. Management assures that all employees are given adequate time and opportunity to complete required education.
3. Any employee that enters into a contract or agreement with a vendor or agent will ensure that the vendor or agent has the required information concerning this Policy.

HUNTERDON HEALTHCARE SYSTEM
ADMINISTRATIVE POLICY AND PROCEDURE MANUAL

Subject: Corporate Compliance Program - Deficit Reduction Act of 2005	No. HHS-109	Date: 3/2007
	Page: 7	Of: 8

Reporting:

1. It is the duty of every employee to report concerns of possible violations of this policy. No adverse action or retribution of any kind will be taken by HHS against a staff member because he or she reports, in good faith, a suspected violation of this policy or other irregularity by any person other than the reporting member. HHS will attempt to treat such reports confidentially to the maximum extent consistent with fair and rigorous enforcement of the Code of Ethics.
2. All employees are expected to report any suspected violations of this policy or other irregularities to their supervisor, manager, director or to the Compliance Officer (908) 237-5468. If the staff member wishes to remain anonymous, he or she may submit his/her report in writing through inter-office mail to the Compliance Officer or through the Corporate Compliance Hotline (908) 788-2585. All reports submitted in writing or through the voice mailbox system must contain sufficient information for the Compliance Officer to investigate the concerns raised.
3. Upon receipt of a credible report of suspected violations or irregularities, the Compliance Officer shall immediately begin a detailed investigation in compliance with Administrative Policy # HHS-108 – Resolution of Corporate Compliance Complaints, as detailed below:
 - a. All complaints received by the Corporate Compliance Department will be addressed and a written response completed within ten (10) business days of the receipt of the complaint. Any complaint received that is not appropriate for the Corporate Compliance Department will be referred to the proper Director or Administrator. The Corporate Compliance Department will monitor referred complaints to ensure timely response.
 - b. For any complaint requiring an investigation by the Corporate Compliance Department, a resolution plan will be documented, presented to and approved by the Corporate Compliance Committee within thirty (30) calendar days from the receipt of the complaint.
 - c. All resolution plans should be implemented and a final complaint summary completed within ninety (90) calendar days of the receipt of the original complaint. The final summary will be filed in the Compliance Department and made available to the Compliance Committee, the President and Chief Executive Officer and the complainant.

