CHAMPAIGN COUNTY NURSING HOME
SUMMARY OF ANTI-FRAUD AND ABUSE POLICIES

1. PURPOSE

Champaign County Nursing Home ("CCNH") has established anti-fraud and abuse policies to prevent fraud, waste, and abuse of the Medicaid and Medicare programs. The complete versions of these policies are printed in CCNH's Employee Handbook; they are available online at co.champaign.il.us/ccnh and from CCNH's Compliance Officer

These policies play a central role in the CCNH's efforts to prevent and detect fraud, waste, and abuse in federal health care programs by emphasizing the following primary goals:

Inform: First, the purpose of these policies is to provide information, written policies, and education about certain federal and state laws, including the Federal False Claims Act ("FFCA"), Section 6032 of the Deficit Reduction Act of 2005 ("DRA"), and Illinois Department of Healthcare and Family Services ("IDHFS") regulations, concerning the submission of false and fraudulent claims for healthcare payments to the government, as well as the penalties associated with submitting false and fraudulent claims.

Comply: Second, the purpose of these policies is to ensure CCNH fully complies with all applicable state and federal laws and regulations relating to the documentation, billing, reimbursement, and payment for healthcare services and the submission of claims to federal healthcare programs. These policies ensure appropriate monitoring and auditing to detect and prevent errors in coding and billing.

Commit: Third, the purpose of these policies is to ensure that all those associated with CCNH, its board members, physicians, employees, vendors, independent contractors, and volunteers, remain committed to and informed of their responsibilities to help maintain high ethical standards in all aspects of patient care and business relationships.

Protect: Lastly, the purpose of these policies is also explain the legal remedies and protections available to those who report false and fraudulent claims. These policies also protect the integrity and reputation of CCNH by ensuring all fraud complaints are taken seriously and appropriately investigated.

II. APPLICABILITY

The policies outlined herein apply to all CCNH employees involved with the documentation, billing, and/or submission of claims to federal health care programs. These policies also apply to medical staff, contractors, agents, and all other persons,

groups, or entities providing services, components, or supplies relating to health care programs and services provided by CCNH.

III. DEFINITIONS

As used in CCNH's anti-fraud and abuse policies, these terms are defined as follows:

Abuse generally includes provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost, or in reimbursement for services that are above those actually rendered, or that are not medically necessary.

Claim includes any billing to the Medicare, Medicaid, or other state of federal programs.

False Claim means: (1) knowingly presenting to the U.S. Government a false or fraudulent claim for payment or approval; (2) knowingly making or using a false record or statement to get a false or fraudulent claim paid or approved; (3) conspiring with another to get a false or fraudulent claim paid or allowed; or (4) knowingly making or using a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property.

Fraud is an intentional deception or misrepresentation that the individual or entity makes knowing that the misrepresentation could result in some unauthorized benefit to the individual or the entity, or to some other party.

Knowingly means that a person, with respect to information: 1) has actual knowledge of the information; (2) acts in deliberate ignorance of the truth or falsity of the information. Or (3) acts in reckless disregard of the truth or falsity of the information.

Remuneration means any kickback, bribe, discount, rebate made in cash or in kind, regardless of whether it was paid directly or indirectly. The U.S. Government very broadly defines the word remuneration. Remuneration that is intended to induce referrals is banned; as in remuneration that is intended to induce the purchasing, leasing, ordering or arranging for any good;, facility, service or item paid for by a federal healthcare program.

Under Seal means the lawsuit will be confidential when the government investigates it and decides whether to join in the lawsuit. Until the court lifts the seal in whole or in part, no records relating to the case will be publicly disclosed, except to the U.S. Department of Justice.

Whistleblower is generally defined as a person, usually an employee in a government agency or private enterprise, who disclosed to the public or to those in authority, fraud, mismanagement, corruption, illegality, or some other wrongdoing. A

person filing a civil case for a violation of the FFCA is also sometimes called a relator.

IV. REQUIREMENTS CREATED BY SECTION 6032 OF THE DEFICIT REDUCTION ACT OF 2005

Section 6032 of the DRA requires healthcare organizations, such as CCNH, to establish written policies for all employees. The DRA requires such written policies to provide detailed information about the FFCA and other federal laws. The DRA requires that written policies contain detailed previsions outlining the organizations policies for detecting and preventing fraud and abuse. The DRA further requires all employee handbooks to contain detailed discussions of the legal rights and duties created by the FFCA and other applicable laws designed to counter fraud and false claims in healthcare programs as well as a discussion of those laws providing protections to individuals who report such conduct. *See* 42 U.S.C. §1396a(a)(68).

V. SUMMARY OF RIGHTS & DUTIES UNDER THE FEDERAL FALSE CLAIMS ACT

***Suits Filed by the Government*:** A civil lawsuit can be brought by the U.S. Government against any person who knowingly presents a false claim, record or statement to the government for payment. A lawsuit can also be brought against any person who conspires to defraud the government by getting a false or fraudulent claim allowed or paid. The U.S. Department of Justice is responsible for investigating the allegations, filing the action, holding hearings, issuing subpoenas and collecting the penalties assessed. The person can be held responsible for damages for up to three (3) times the amount of each false claim, record or statement submitted plus mandatory penalties ranging from $5,500 to $11,000.

Examples of false or fraudulent claims investigated under the FCCA include: (1) falsifying records; (2) double billing; (3) submitting bills for services that were never performed Administrative Remedies for False Claims and Statements. The FFCA does not apply to claims, records, or statements related to the Internal Revenue Code.

***Suits Filed by Whistleblowers*:** The FFCA also allows "qui tam" actions. These lawsuits are brought on behalf of the government by a private individual, a whistleblower, who knows about the fraud. The whistleblower sues both as an individual and on behalf of the government.

The whistleblower files a lawsuit under seal in a federal district court. The purpose of "sealing" the lawsuit is to permit the government to conduct its investigation without interference from the defendants. If the government joins in the lawsuit, the lawsuit will be directed by the U.S. Department of Justice. If the government does not join the lawsuit, the whistleblower will continue to lead the lawsuit.

Generally, "qui tam" lawsuits must be filed by the later of either: (a) three (3) years after the violation was discovered by the federal official responsible for investigating

violations (but no more than ten (10) years after the violation was committed), or (b) within six (6) years of the date of the fraud.

If the government joins in a "qui tam" lawsuit, and it is successful, the whistleblowers may receive between 15% and 25% of the proceeds of the lawsuit. If the government does not join in the lawsuit and the lawsuit is successful, the whistleblower may receive between 25% and 30% of the proceeds.

In addition to the financial awards provided to the whistleblower, the FCCA strives to make whistleblowers whole and provide them with all relief necessary to do that, such as: employment reinstatement, providing back pay, and other compensation due to an employer's retaliatory conduct against the whistleblower for filing the "qui tam" lawsuit. *See* 31 U.S.C. §3729 *et. Seq*.

VI. PROGRAM FRAUD AND CIVIL REMEDIES ACT

The program Fraud and Civil Remedies Act creates administrative remedies for making false claims and false statements. This Act imposes liability on people or entities that file a claim they know or have reason to kno0w is: (1) false, fictitious, or fraudulent; (2) includes or is supported by any written statement that contains false, fictitious, or fraudulent information; (3) includes or is supported by 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 (4) is for payment for property or services not provided as claimed. These penalties are separate and apart from any liability that may be imposed under the FFCA.

Liability under this Act is also created when a person or entity submits a written statement that they know or should know: (1) asserts a material fact that is false, fictitious, or fraudulent; or (2) 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.

Violation of this Act creates liable for a civil penalty of tut p $5,000 for each false claim submitted and may also be subject to an "assessment" of up to twice the amount of each false claim submitted. *See* 31 U.S.C.§§3801-3812

VII. FEDERAL HEALTH CARE PROGRAM ANTI-KICKBACK LAW

The federal Anti-Kickback Law arose out of congressional concern that payoffs to those who can influence healthcare de3cisions will result in goods and services being provided that are medically unnecessary, of poor quality, or even harmful to a vulnerable patient population. To protect the integrity of the program from these difficult to detect harms, Congress enacted a *per se* prohibition against the payment of kickbacks in any form, regardless of whether the particular kickback gave rise to over utilization or poor quality of care.

***Liability*:** Individuals and entities can be held liable under the Anti-Kickback Law for knowingly and willfully offering, paying, soliciting or receiving remuneration in exchange for referring, furnishing, purchasing, leasing or ordering any good, facility, service or item that is paid for in whole or in part by Medicare or Medicaid programs or other federal health care programs. Both the recipient of the remuneration and the individual or entity who offers the remuneration are subject to the Anti-Kickback Law. A violation of the Anti-Kickback Law can give rise to liability under the FCCA.

***Exceptions*:** The government has issued regulations that create a list of practices that do not violate the Anti-Kickback Law. These practices are commonly referred to as "safe harbors". The safe harbors cover a small number of payment practices. They are narrow exceptions to the Anti-Kickback Law's prohibited practices.

***Damages*:** A person or entity can be held criminally and/or civilly liable for violating the Anti-Kickback Law. The criminal penalty is a fine of up to $25,000 and/or imprisonment of up to five (5) years. An Anti-Kickback Law violator can also be excluded from participation in a federal health care program. On the civil side, a person or entity can be required to pay the government up to (3) three times the amount of the total remuneration offered, paid, solicited or received plus a $50,000 fine for each violation of the Anti-Kickback Law. *See* 42 U.S.C. §1320a-7b(b).

VIII. APPLICABLE ILLINOIS STATE LAW

***Medical Provider Participation*:** Consistent with the DRA and the FFCA, IDHFS requires certain Illinois healthcare organizations, such as CCNH, to provide it with proof of education and written policies illustrating DRA and FFCA compliance when asked. *See* 89 III. Admin.Code 140.12(e).

***Illinois Whistleblower Act*:** Under this law, employer are prohibited from making or enforcing rules or policies preventing employees from disclosing information to a government or law enforcement agency when the employee has information regarding a violation of a state or federal law, rule, or regulation. Employer retaliation for such disclosures, even by contractual workers, is prohibited. Likewise, employers may not retaliate against employees for their refusal to participate in an activity that would result in a violation of a state or federal law, rule, or regulation. Employees may bring a civil action against the employer "for all relief necessary to make the employee whole," including reinstatement, back pay with interest, and litigation costs. *See* 740 ILCS 174/1 *et seq*.

***Illinois Whistleblower Reward and Protection Act*:** In 1992, Illinois enacted this Act, which closely tracks the federal FFCA. This Act imposes civil liability upon "any person" who "knowingly presents, or causes to be presented, to an officer or employee of the State…a false or fraudulent claim for payment or approval." Violations of this act may result in liable to the state for a civil penalty of not less than $5,000 and not more than $10,000, plus treble damages. *See* 740 ILCS 175/1 *et seq*.

Similar to the FFCA, an employee "whistleblower" may receive a portion of that award plus attorney fees and expenses. There are some restrictions on the eligibility of whistleblowers. For example, information obtained from other publicly available sources cannot be the basis for the lawsuit. The whistleblower must be the original source of the information. This Act protects employees from employer retaliation. If terminated for engaging in the activity protected by this law, an employee could be entitled to reinstatement with seniority status and double the amount of back pay with interest, and litigation cost.

***Illinois Public Assistance Fraud Act*:** Actions under this law may be initiated by the Illinois Attorney General or by a County State's Attorney when a unit of local government is involved. This law makes it a Class A misdemeanor to make false statements "relating to health care delivery." Obtaining any payment by means of a false statement or representation, or by concealment of any material fact, requires the repayment of any excess payments along with interest and other penalties. Violations may also result in a hospital being prohibited from future participation in any state health plans. *See* 305 ILCS 5/8A-1 *et seq*.

***Illinois Public Aid Code*:** This law is designed to counter fraudulent Medicaid insurance claims and also fraudulent claims by an individual to obtain public assistance in Illinois. *See* 305 ILCS 5/8A-3 *et seq*.

***Illinois Insurance Claims Fraud Prevention Act*:** This act criminalizes the act of offering any remuneration to induce a person to obtain services or benefits under a contract of insurance or to file a false claim related to insurance. A private individual (a whistleblower) may bring an action to enforce this statute. If the action is successful, the person bringing the action will receive a portion of the amount recouped, which CNA be as significant as 50% of the amount recouped from the entity or person committing the insurance fraud. Actions under this statute include actions to recoup Medicaid payments made as a result of a false claim. Employer retaliation against employees bringing such claims is prohibited. Any retaliation will result in reinstatement and the payment of two (2) times the amount of any back pay and possibly special damages resulting from the retaliatory action. *See* 740 ILCS 92/1 *et seq*.

***Insurance Fraud under the Illinois Criminal Code*:** The Illinois Criminal Code contains several provisions criminalizing insurance fraud. In addition to making insurance fraud a criminal act, the Illinois Criminal Code also creates a cause of action for civil damages for insurance fraud or fraud on a governmental entity. Under this statute, the entity committing such fraud may be liable for up to three (3) times the value of the fraudulent claim. This statutory section creates a cause of action only for the affected insurance company or governmental-not the whistleblower. *See* 720 ILCS 5/46-1 thru 46-6.

IX. OVERVIEW OF CCNH REPORTING REQUIREMENTS & WRITTEN POLICIES

CCNH strives to prevent, detect, and report violations of state and federal laws, and expects that its employees will do the same. CCNH utilizes the following measures in its continuing efforts to uphold high ethical standards and meet the primary goals (to inform, comply, commit, and protect) of its anti-fraud and abuse policies:

- All new employees will receive comprehensive training regarding CCNH's anti-fraud and abuse policies.

- All existing employees will receive comprehensive training on an annual basis regarding CCNH's anti-fraud and abuse policies as well as updates on changes in federal and state laws designed to counter fraud and also protect whistleblowers.

- CCNH requires all employees, medical staff, contractors, agents, and persons/entities doing business with CCNH to immediately report suspected fraud and questionable activities to CCNH's Chief Compliance Officer.

- CCNH has anti-fraud and abuse policies outlining procedures for reporting, investigating, and responding to complaints of potential fraud. These policies include protections for those who report potential abuse.

- All complaints of potential fraud are directed to CCNH's Chief Compliance Officer. All complaints are immediately investigated. All reasonable steps are taken to maintain the confidentiality of anyone reporting suspected violations, even if it turns out no actual violation has occurred.

- CCNH's anti-fraud and abuse policies and procedures are reviewed annually to ensure compliance with all relevant laws and regulations.

CCNH's anti-fraud and abuse policies are provided in the CCNH Employee Handbook. These policies are also available to the public online at co.champaign.il.us/ccnh and from CCNH's Chief Compliance Officer *(Andrew Buffenbarger, (217)384-3784 ext. 5200)*

X. REFERENCES & RESOURCES

Relevant Federal Laws

Deficit Reduction Act of 2005, 42 U.S.C. §1396a(a)(68);
False Statements, 18 U.S.C. §1001;
Federal False Claims Act, 31 U.S.C. §3729 *et, seq*.;
Federal Remedies, 31 U.S.C. §§ 3801-3812;
Mandatory Exclusions/Civil Penalties, 42 U.S.C. §§ 1320a-7, 1320a-7a, 1320a-7b(b);
Medicare and Medicaid Anti-Kickback Provisions, 42 C.F.R. Part 1001; 1001.952 *et seq.;*
Medicare and Medicaid Fraud, 42 U.S.C. § 1320a-7b(a)(1);
Medicare Part D Prescription Drug Benefit Regulations, 28 C.F.S. §85.3 42 C.F.R. §423.504(B)(4)(vi)(H);
Program Fraud and Civil Remedies Act, 31 U.S.C. §§3801-3812; and

Submitting False Claims, 18 U.S.C. §287.

While they do not afford any specific whistleblower protections, the following statutes may assist in the prosecution of those who retaliate against whistleblowers:

Major Fraud Act of 1989, 18 U.S.C. §1031;
Penalties for obstruction of government investigations, 18 U.S.C. §1505; and
Penalties for obstruction of government agency proceedings, 45 U.S.C. §60.

Illinois State Laws

Medical Provider Participation, 89 III. Admin.Code 140.12(e);
Illinois Whistleblower Act, 740 ILCS 174/1 *et seq.;*
Illinois Whistleblower Reward and Protection Act, 740 ILCS 175/1 *et seq.;*
Illinois Public Assistance Fraud Act, 305 ILCS 5/8A-1 *et seq*.;
Illinois Public Aid Code, 305 ILCS 5/8A-3 *et seq.;*
Illinois Insurance Claims Fraud Prevention Act, 740 ILCS 92/1 *et seq.;* and
Illinois Criminal Code addressing Insurance Fraud, 720 ILCS 5/46-1 thru 46-6.

CCNH Policies & Procedures

Employee Handbook
Specific CCNH Policies. Reporting/non-retaliation Policy
Website: co.champaign.il.us/ccnh