Penn Medicine Princeton Health

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<tr><td>Submitted by:

Nancy Fletcher, Vice President
and General Counsel</td><td rowspan="2">Approval:

Barry S. Rabner
President & CEO PHCS</td><td colspan="2">Number:
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I. Background

Submission of false information and claims to the Federal Government may constitute a fraud that is actionable by enforcement agencies under the False Claims Act. The Office of Inspector General (OIG), U. S. Department of Health and Human Service, conducts a large number of Medicaid audits and evaluations to determine improper or fraudulent payments which result in a substantial drain on state and federal funds. The Deficit Reduction Act (DRA) of 2005 mandated that any entity receiving or making annual payments under the State Medicaid plan of at least $5 million must:

- "Establish written policies for all employees of the entity (including management), and of any contractor or agent of the entity, that provide detailed information about the False Claims Act (FCA) established under sections 3729 through 3733 of Title 31, United States Code, administrative remedies for false claims and statements established under Chapter 38 of Title 31, United States Code, any State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in federal health care programs (as defined in section 1128B(f)); and,

- Include, as part of such written policies, detailed provisions regarding the entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

II. Purpose

PHCS is committed to complying with all applicable laws and regulations. PHCS supports the efforts of federal and state authorities in identifying incidents of fraud and abuse and has the necessary and appropriate procedures in place to prevent, detect, report and correct incidents of fraud and abuse in accordance with contractual, regulatory and statutory requirements. This policy sets forth the guidelines to be followed by all employees, contractors and agents regarding the FCA in detecting preventing, reporting and correcting fraud, waste and abuse.

III. Definitions

Fraud: An intentional (willful or purposeful) deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/herself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.

Abuse: Practices that are inconsistent with sound fiscal, business or medical practices, and that result in an unnecessary cost to government programs, or in seeking reimbursement for goods or services that are not medically necessary or that fail to meet professionally recognized standards for healthcare.

Contractor or Agent: Includes any contractor, subcontractor, agent, or other person which or who, on behalf of PHCS, 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 PHCS, including, but not limited to, physicians with privileges.

Relevant Federal and State Statutes

Below find a summary of certain statutes that provide liability for false claims and statements. These summaries outline some of the major statutory provisions required by the DRA.

1. Federal False Claims Act, 31 U.S.C. 3729-3733

The provisions under the False Claims Act (FCA) state that it is a violation to:

- Knowingly present or cause to be submitted a false claim to the government.

  For purposes of this section, the terms "knowing" and "knowingly" mean 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,

and no proof of specific intent to defraud is required.

- Knowingly use a false record or statement to obtain payment on a false claim paid by the government.

- Engage in a conspiracy to defraud the government by the improper submission of a false claim for payment.

Damages and penalties for violating the FCA may include:

- Civil penalties of not less than $ 5,500 (minimum) and not more than $11,000 per violation, for violations occurring prior to November 2, 2015 ***plus***

- Three times the amount of damages which the government sustains because of the violation.

- Exclusion from participation in Medicare and other health care programs

The FCA provides for "Whistleblower" protection and the assurance of non-retaliation against an employee/vendor who reports any type of false claims and statements.

2. Civil Monetary Penalties Inflation Adjustment Act of 2015

This Act allows the Department of Justice (DOJ) to adjust civil monetary penalties assessed or enforced by components of the Department. For civil penalties assessed after June 19, 2020, whose associated violations occurred after November 2, 2015, the civil monetary penalties provided by law within the jurisdiction of the Department are adjusted as set forth in the seventh column of the following table. For civil penalties assessed after January 29, 2018, and on or before June 19, 2020, whose associated violations occurred after November 2, 2015, the civil monetary penalties provided by law within the jurisdiction of the Department are those set forth in the sixth column of table 1 to this section. For civil penalties assessed after February 3, 2017, and on or before January 29, 2018, whose associated violations occurred after November 2, 2015, the civil monetary penalties provided by law within the jurisdiction of the Department are those set forth in the fifth column of table 1 to this section. For civil penalties assessed after August 1, 2016, and on or before February 3, 2017, whose associated

violations occurred after November 2, 2015, the civil monetary penalties provided by law within the jurisdiction of the Department are those set forth in the fourth column of table 1 to this section. All figures set forth in this table are maximum penalties, unless otherwise indicated:

Table 1

U.S.C. Citation	Name/Description	CFR	DOJ penalty assessed after 8/1/16($)	DOJ penalty assessed after 2/3/17($)	DOJ penalty assessed after 1/29/2018($)	DOJ penalty assessed after June 19, 2020($)
31 U.S.C.3729(a) (a)(1)	False Claims Act Violations	28CFR85.3 (a)(9)	Min 10,781, Max 21,563	Min 10,957, Max 21,916	Min 11,181, Max 22,363	Min 11,665, Max 23,331.
31 U.S.C.3802 (a)(1)	FCA-Program Fraud False Claims(per claim)	28CFR71.3(a)	$10,781	$10,957	$11,181	$11,665.
31 U.S.C.3802(a)(2)	FCA-Program Fraud, False Statements(per statement)	28CFR85.3	$10,781	$10,957	%11,181	$11,665.

***Qui Tam* Provisions (whistleblower rights)**: This provision of the FCA allows a person to bring an action under the FCA on behalf of the Federal Government and share in any recovery.

3. Federal Program Fraud Civil Remedies Act, 31 U.S.C. 3801-3812

The **Program Fraud and Civil Remedies Act of 1996 (PFCRA)** creates administrative remedies for making false claims and false statements including those made to federally funded health care programs. These penalties are separate from and in addition to any liability that may be imposed under the FCA.

4. New Jersey Medical Assistance and Health Services Act

Criminal Penalties, N.J.S. A. 30:4D-17(a)-(d)

Provides for the imposition of penalties not more than $10,000 or imprisonment of not more than three (3) years or both, for individuals and entities engaging in fraud or other criminal violations related to Title XIX funded programs such as Medicaid. Participants engaging in criminal violations may be excluded from participation in Medicaid and other health care programs under N.J.S.A. § 30:4D-57.

Civil Remedies, N.J.S. A. 30:4D-7.h., N.J.S. 30:4D-17(e)-(i); N.J.S. 30:4D-17.1.a

Allows for the imposition of civil penalties of payment of interest on the amounts of excess benefits or payments made, payment of up to three times the amount of excess

benefits or payments made and payment between $10,781 and $21,563 for each excessive claim for assistance, benefits or payments. Participants engaging in civil violations may be excluded from participation in Medicaid and other health care programs under N.J.S.A. § 30:4D-17.1(a)

5. Health Care Claims Fraud Act N.J.S. A. 2C:21-4.2 & 4.3; N.J.S. 2C:51-5

Provides for automatic permanent forfeiture of health care licenses for those convicted of health care claims fraud in the second degree, and a one-year suspension for those convicted of health care claims fraud in the third degree. The Act also provides for imprisonment of up to 10 years for fraudulent claims submitted for professional services and payment fines for up to $150,000 or up to five times the amount of the fraudulent claim.

6. Conscientious Employee Protection Act (CEPA), "Whistleblower Act", N.J.S.A. 34:19-4

(See PMPH Human Resource CEPA policy).

7. New Jersey False Claims Act, N.J.S.A. 2C:32-1 et seq.

The New Jersey False Claims Act (NJFCA) amends the NJ Medicaid Statute and 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. Under NJFCA, the civil penalties are between $10,781 and $23,331 per false or fraudulent claim.

1. In accordance with applicable laws, all employees, contractors and agents are required to conduct themselves in an ethical and legal manner, shall not knowingly engage in practices which constitute fraud and abuse, and shall maintain accurate records related to billing and coding practices.

2. All employees, contractors and agents are responsible for reporting potential or suspected incidents of fraud and abuse, and other wrongdoing relating to federal and state reimbursement directly to their supervisor and/or management or by using one of the reporting methods described in the procedures section of this policy. For the remainder of this policy "Fraud/Abuse" shall include fraud, abuse and other wrongdoing relating to federal reimbursement.

3. The Chief Compliance Officer or his/her designee has responsibility for investigating all information suggesting the existence of potential Fraud/Abuse and for directing all investigations arising from this information as provided for in section V of this policy.

4. If the Chief Compliance Officer or his/her designee reasonably believes that allegations of Fraud/Abuse constitute potential violations of law, such allegations shall be

disclosed to a duly authorized law enforcement agency in consultation with senior management and/or the Board of Trustees.

IV. Procedures

1. All employees, contractors or agents (as defined above) with knowledge of suspected or what they believe may be Fraud/Abuse situations must report such situations through any of the following methods:

- Notifying their direct supervisor; **or**
- Notifying any supervisor or member of management; **or**
- Notifying Human Resources management; **or**
- Contacting the PMPH Compliance Officer/Corporate Compliance Office directly at 609-835-7140; **or**
- Calling the confidential PMPH Compliance Hotline at 1-215-PCOMPLY.

2. Anyone receiving a report of potential Fraud/Abuse *(e.g.,* management, human resources, legal counsel) should immediately inform the Chief Compliance Officer or his/her designee. The Chief Compliance Officer or his/her designee will analyze the report, and, when necessary, conduct an "initial inquiry" for the sole purpose of determining whether there is a reasonable basis to support further investigation. No supervisor or manager should directly confront an employee with the allegation of Fraud/Abuse or otherwise discuss the issue with anyone suspected of engaging in Fraud/Abuse without prior consultation with and authorization from either the Vice President of Human Resources or the Chief Compliance Officer.

3. If the Chief Compliance Officer or his/her designee determines that there is a reasonable basis to support further investigation, it is the responsibility of the Chief Compliance Officer or his/her designee to ensure that the incident is appropriately handled by qualified personnel, and, when deemed appropriate, reported to an appropriate law enforcement agency. In conducting an investigation of wrongdoing, facts should be gathered as promptly as possible.

4. Legal counsel shall provide privileged advice to the Chief Compliance Officer or his/her designee as appropriate throughout the process.

5. The Chief Financial Officer and finance personnel also may be used to determine the extent of financial liability resulting from inappropriate claims submission, as well as to assist in planning the appropriate course of action to correct deficiencies and resolve any financial liability issues.

6. Senior management may designate authority to appropriate employees to be responsible for developing effective controls for the prevention, detection, reporting and

correction of potential incidents of Fraud/Abuse. With oversight and support from the Chief Compliance Officer or his/her designee, PMPH will establish and maintain methods for detecting-preventing, reporting and correcting incidents of fraud and abuse, maintain a compliance hotline and a process that identifies employees, contractors, and agents that are debarred or excluded from participating in federal programs.

7. If incidents of Fraud/Abuse are identified, appropriate corrective action will be taken (including systematic changes, if appropriate) to prevent further offenses.

8. To the extent practical or allowed by law, the Compliance Officer or his/her designee must maintain the confidentiality or anonymity of an employee or other complainant when requested. However, absolute confidentiality cannot be promised or guaranteed.

9. PMPH cooperate fully with federal and state agencies that conduct healthcare fraud and abuse investigations. However, this does not prevent PMPH from raising any defenses it may have or require PMPH to waive any privileges that it may have.

10. PMPH will take appropriate corrective action against employees, contractors, and agents found to have committed Fraud/Abuse. Corrective action may include discipline up to and including termination of the employment or other relationship.

11. Upon completion of investigations, appropriate corrective action shall be taken (including immediate systematic changes, if appropriate) to prevent similar problems from occurring in the future.

12. Consistent with PMPHS's Code of Ethical Conduct, all individuals subject to this Policy should promptly report suspected Fraud/Abuse and participate in and not interfere with any investigation of Fraud/Abuse.

13. Retaliation or retribution of any kind for reporting issues "in good faith" for participating in an investigation in any capacity in "good faith" is prohibited and will result in corrective action, such as discipline, up to and including termination of the employment or other relationship.

V. Other Relevant PMPH Corporate Compliance Policies

- Voluntary Reporting of any Compliance Misconduct
- Corporate Compliance Hotline
- Compliance Issue Resolution
- Auditing, Monitoring and Issue Resolution
- Code of Ethical Conduct

VI. Relevant PMPH Human Resource Policy

- Conscientious Employee Protection Act (CEPA)

NJ Reference Authority / Citations

- New Jersey Medical Assistance and Health Services Act – Criminal Penalties,
  N.J.S. 30:4D-17(a) – (d)

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

- Health Care Claims Fraud Act, N.J.S. 2C:21-4.2 and 4.3; N.J.S. 2C:51-5

- Conscientious Employee Protection Act, N.J.S. 34:19-1 et seq.

- New Jersey False Claims Act, P.L. 2007, Chapter 265, enacted January 13, 2008, and effective 60 days after enactment, adding N.J.S. 2A:32C-1 to 2A:32C-17, and amending N.J.S. 30:4D-17(e)