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ADDITIONAL APPROVAL(S): **None.**

SUBJECT: **Compliance with Federal and State False Claims Acts**

Purpose:

To educate all Hospital employees, Medical Staff, Contractors and Agents (collectively, "Personnel") on the Federal and State False Claims laws in accordance with the requirements of the Deficit Reduction Act of 2005, Sections 6031, 6032. To ensure that all Personnel are aware of the Hospital's policies designed to detect and prevent fraud, waste and abuse of the funds expended in government healthcare programs, such as Medicare and Medi-Cal.

Policy:

It is the policy of the Hospital to provide healthcare services in compliance with all applicable Federal and State laws, including the submission of accurate claims to State and Federal healthcare programs. Therefore, Personnel will not knowingly submit a false or fraudulent statement or claim for payment, or use a false record to receive payment, or conspire to defraud the government, or submit a record to avoid or decrease an obligation to pay money to the government (such as refunding an overpayment).

Definitions:

Contractor or Agent – means any contractor, subcontract, agent, or other person or entity which furnishes Medicaid healthcare items or services, performs billing or coding functions, or is involved in monitoring of the healthcare services provided by the Hospital.

Summary of Laws:

1. False Claims Laws General Information

One of the primary purposes of any false claims law is to combat fraud and abuse in government programs. Under the False Claims laws the government is allowed to bring civil actions to recover damages and impose penalties when false claims are submitted. These laws often permit qui tam lawsuits (whistleblowers suits) as well, which are lawsuits brought by lay people that suspect false claims have been submitted.

There is a federal False Claims Act and various states have adopted False Claims Laws. Under the federal False Claims Act, any person or entity that knowingly submits a false or fraudulent claim for payment of United States Government funds is liable for significant penalties and fines. The fines include a penalty of up to three times the Government's damages, civil penalties ranging from \$5,500 to \$11,000 per false claim, and the costs of the civil action against the entity that submitted the false claims. Generally, the federal False Claims Act applies to any federally funded program including claims submitted by healthcare providers to Medicare or Medicaid.

2. Qui Tam Provision

One of the unique aspects of the federal False Claims Act is the qui tam provision, commonly referred to as the whistleblower provision. This provision allows a private person with knowledge of a false claim to bring a civil action on behalf of the United States Government ("Government"). The purpose of bringing the qui tam suit is to recover the funds paid as a result of the false claims. If the suit is ultimately successful, the whistleblower that initially brought the suit may be awarded a percentage of the funds recovered. Sometimes the Government decides to join the qui tam suit. In such cases, the Government assumes responsibility for all of the expenses associated with the suit and the percentage received by the whistleblower will be lower than if the Government had not joined the lawsuit.

Regardless of whether the Government participates in the lawsuit, the court may reduce the whistleblower's share of the proceeds if the court finds that the whistleblower planned and initiated the false claims violation. Further, if the whistleblower is convicted of criminal conduct related to his role in the preparation or submission of the false claims, the whistleblower will be dismissed from the civil action without receiving any portion of the proceeds.

3. Non-Retaliation Provisions

The federal False Claims Act also contains a provision that protects a whistleblower from retaliation by his or her employer. This applies to any employee who is discharged, demoted, suspended, threatened, harassed, or discriminated against in his or her employment as a result of the employee's lawful acts in furtherance of a false claims action. The whistleblower may bring an action in the appropriate federal district court and is entitled to reinstatement with the same seniority status, two times the amount of back pay, interest on the back pay, and compensation for any special damages as a result of the discrimination, such as litigation costs and reasonable attorney fees.

4. California False Claims Act

California law prohibits conduct similar to that addressed under the federal FCA. California Government Code Sections 12650-12656 (commonly known as the California False Claims Act or CFCA), prohibit any person from submitting a false or fraudulent claim over \$500 to the state or local government. The CFCA also makes it illegal for any person who benefits from a false claim, and later discovers the falsity of the claim, to fail to disclose the false claim to the applicable state or local government. The CFCA does not apply to workers' compensation claims, tax claims, or claims against public entities and employees. California officials may file a lawsuit against a suspected violator of the CFCA, or alternatively, a private individual, such as an employee, may file a qui tam lawsuit on behalf of the government. California officials may choose to participate in the qui tam lawsuit or allow the individual to proceed alone on the state or local government's behalf. If the case is successful, the individual is entitled to a portion of the government's monetary recovery. Employees who assist or participate in an action under the CFCA are protected from workplace retaliation. The CFCA imposes

a civil penalty of up to \$10,000 for each separate violation of the law. Violators may also need to pay the applicable state or local government an amount equal to two to three times the value of the false claim.

California Welfare & Institutions Code Section 14107 prohibits fraud involving funds of the state's medical assistance programs, including Medi-Cal. This statute establishes grounds for both criminal and civil actions against any person who knowingly defrauds Medi-Cal or other state medical assistance programs by submitting false claims or making false representations. These actions, however, may only be brought by state officials; private individuals cannot file qui tam lawsuits under this provision. Penalties for a violation of this statute include imprisonment and/or a fine not exceeding three times the amount or value of the fraud.

California Insurance Code Section 1871.7 prohibits a person from knowingly presenting a false claim for a health care benefit to a private insurer. Actions under this statute may be brought by the district attorney or California Insurance Commissioner or alternatively, a qui tam lawsuit may be filed on behalf of the state by a private individual, such as an employee. The state or district officials may choose to participate in the qui tam lawsuit or allow the individual to proceed alone on the state's behalf. If the case is successful, the individual is entitled to a portion of the state's monetary recovery. Employees who assist or participate in an action under this statute are protected from workplace retaliation. Penalties for a violation of this statute include a civil penalty between \$5,000 to \$10,000, plus an assessment not exceeding three times the amount of each fraudulent claim. In addition, there may be a separate criminal prosecution for violations of this statute.

Reporting Concerns Regarding Fraud, Abuse and False Claims:

Ridgecrest encourages all Personnel to be aware of the laws regarding healthcare fraud, waste, abuse and false claims and to identify and resolve any issues as quickly as possible. Issues are resolved fastest and most effectively when concerns are brought to the attention of the immediate supervisor or manager. Concerns can also be brought to the attention of the compliance department or can be anonymously reported on the compliance hotline at 760-499-3675.

Anti-Retaliation Protections:

Ridgecrest has adopted a policy prohibiting retaliation and it will not retaliate or discriminate against any Personnel who, acting in good faith, investigates, reports or assists in uncovering what they perceive to be a false claim submitted to the government for payment.

Hospital's Policies & Procedures for Detecting and Preventing Fraud:

- The Hospital has numerous policies that support its commitment to detect and prevent fraud, waste and abuse of Federal and State healthcare dollars, such as its Corporate Compliance Plan, policies to present accurate claims for payment, policies addressing accurate cost reporting, accurate coding, and accurate documentation of all services provided.
- The Hospital also has policies that encourage employees to report suspected fraud, waste or abuse of Federal or State healthcare expenditures, including reporting anonymously through the Compliance Hotline and an open door policy as stated in the Employee Handbook.
- The Hospital has a policy to prohibit discrimination or retaliation for the reporting of suspected fraud, waste or abuse of Federal or State healthcare expenditures.
- The Hospital is proactive in its efforts of fraud and abuse detection through its internal and external audits and reviews, including in the areas of coding and billing, clinical quality, and cost reports.

Enforcement:

All employees whose responsibilities are affected by this Policy are expected to be familiar with the basic procedures and responsibilities created by this Policy. Failure to comply with this Policy will be subject to appropriate performance review pursuant to all applicable policies and procedures, up to and including termination.

Procedures:

- This policy shall be disseminated by posting the policy on the RRH website and thus shall be available to all employees, contractors, agents and medical staff.
- Director of Human Resources is responsible to ensure that all new employees and independent contractors processed through the HR department (such as Traveler's) are made aware that this policy is available via the RRH website.
- This policy will be covered in orientation. Employees will also receive training on the False Claims Act through the online training program that is taken by all new employees within 30 days of hire and on an annual basis thereafter.
- The Director of Materials Management is responsible to ensure that vendors providing healthcare goods are aware that this policy is available via the RRH website.
- The Medical Staff Office Manager is responsible to ensure that all active members of the medical staff are aware that this policy is available via the RRH website.
- The Hospital's Employee Handbook shall contain information regarding the False Claims Act as required by law.

References:

- Deficit Reduction Act of 2005, Sections 6031, 6032
- Federal False Claims Act (31 U.S.C. 3729-3733)
- California Government Code Sections 12650-12656
- California Welfare & Institutions Code Section 14107
- California Insurance Code Section 1871.7