

FALSE CLAIMS POLICY**Policy # 103.1**

Section: <i>Corporate Standards</i>	Effective Date: <i>July 2007</i>
	Revision Date(s):
Regulation(s): <i>Deficit Reduction Act (DRA) 2005, False Claims Act, 31 U.S.C. §§3729-3733 (FCA), Federal Program Fraud Civil Remedies Act of 1986, 38 U.S.C. §3801 et seq. (Act)</i>	

BACKGROUND: The submission of false information and claims to the federal government may constitute fraud that is actionable by enforcement agencies. The Office of the Inspector General of the U.S. Department of Health and Human Services and state Medicaid Fraud Units conduct a large number of Medicaid audits and investigations to evaluate 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 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”.

PURPOSE: VistaCare is committed to complying with all applicable laws and regulations. VistaCare supports the efforts of federal and state authorities in identifying incidents of fraud and abuse and has the necessary procedures in place to prevent, detect, report and correct incidents of fraud and abuse in accordance with contractual, regulatory and statutory requirements. This False Claims Policy sets forth the guidelines to be followed by all employees (and others as applicable) regarding the False Claims Act, the Federal Program Fraud Civil Remedies Act of 1986, and in detecting and preventing fraud, waste and abuse.

Definitions

“Fraud” is defined as 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” is defined as 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. It also includes member practices that result in unnecessary cost to government programs.

Federal False Claims Act:

The federal False Claims Act (the "FCA") is a statute that imposes liability on any person who:

- Knowingly presents or causes to be presented a false or fraudulent claim to the government.
- Knowingly uses a false record or statement to obtain payment on a false claim paid by the government.
- Engages in a conspiracy to defraud the government by the improper submission of a false claim for payment.

The term "**knowingly**" is defined to mean that with respect to information a person has actual knowledge of the information, acts in deliberate ignorance of the truth or falsity of the information, or acts in reckless disregard of the truth or falsity of the information. No proof of specific intent to defraud is required.

The term "**claim**" includes any request or demand for money or property if the United States Government provides any portion of the money requested or demanded.

The FCA applies to Medicare and Medicaid reimbursement and prohibits, among other things:

- Billing for services not rendered
- Billing for undocumented services
- Making improper entries on cost reports
- Billing for medically unnecessary services
- Assigning incorrect codes to secure higher reimbursement
- Characterizing non-covered services or costs in a way that secures reimbursement
- Failing to seek payment from beneficiaries who may have other primary payment sources, and;
- Participating in kickbacks

Damages and penalties of violating the FCA include:

- Civil penalties of not less than \$5,500 and not more than \$11,000 per violation, plus
- Three times the amount of damages which the government sustains because of the violation, and the costs of any civil action brought to recover such penalties or damages.

The FCA also provides for actions by private persons (*qui tam* lawsuits), and private persons may bring a civil action in the name of the government for a violation of the FCA. Generally, the action may not be brought more than six years after the violation, but in no event more than ten years. The United States Government may choose to intervene in the lawsuit and assume primary responsibility for prosecuting, dismissing or settling the action. If the government chooses not to intervene, the person who initiated the lawsuit (the "Whistleblower") has the right to conduct the action. In the event that the action is successful, the Whistleblower may be awarded a portion of the funds recovered. When the government intervenes the Whistleblower

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may receive at least 15 percent but not more than 25 percent of the proceeds of the action depending upon the extent to which the individual contributed to the prosecution of the action. When the government does not intervene the FCA provides that the Whistleblower may receive not less than 25 percent and not more than 30 percent of the proceeds of the action as determined by the court. The Whistleblower may also receive an amount for reasonable expenses plus reasonable attorneys' fees and costs.

If the civil action is frivolous, clearly vexatious, or brought primarily for harassment, the Whistleblower may have to pay the defendant its fees and costs. The amount received by the Whistleblower will be decreased if he/she planned or initiated the violation, and no share will be awarded if the Whistleblower is found guilty of a crime associated with the violation.

The FCA also provides for protection for employees from retaliation. If an employee is discharged, demoted, suspended, threatened, harassed, or discriminated against in terms and conditions of employment because of lawful acts conducted in furtherance of an action under the FCA, that employee may bring an action in federal court seeking reinstatement, two times the amount of back pay plus interest, and other enumerated costs, damages, and fees.

Federal Program Fraud Civil Remedies Act of 1986:

The Federal Program Fraud Civil Remedies Act of 1986 (the "Act") establishes an administrative remedy against any person who presents or causes to be presented a claim or written statement that the person knows or has reason to know is false, fictitious, or fraudulent due to an assertion or omission to certain federal agencies (including the Department of Health and Human Services).

The term "**knows or has reason to know**" is defined in the Act as a person who has actual knowledge of the information, acts in deliberate ignorance of the truth or falsity of the information, or acts in reckless disregard of the truth or falsity of the information. No proof of specific intent to defraud is required.

With regard to this Act, the term "**claim**" includes any request or demand for property or money, e.g., grants, loans, insurance or benefits, when the United States Government provides or will reimburse any portion of the money.

The Act allows for civil monetary sanctions to be imposed in administrative hearings, including penalties of \$5,000 per claim and an assessment, in lieu of damages, of not more than twice the amount of the original claim.

State False Claims Act:

State specific False Claims Act information is available at VistaCare.com

Policies & Procedures for Detecting Fraud, Waste, and Abuse:

VistaCare has adopted the following for detecting fraud, waste, and abuse:

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Policies:

1. All employees, officers, directors, volunteers and all other company agents and representatives (and other parties as applicable) must conduct themselves in an ethical and legal manner, including the maintenance of accurate records related to their business activities.
2. All employees, officers, directors, volunteers and all other company agents and representatives are responsible for reporting potential or suspected incidents of fraud and abuse, and other wrongdoing of VistaCare directly to their supervisor and executive management or by using one of the reporting methods described in the procedures section of this policy.
3. VistaCare shall educate employees about fraud and abuse, including the detailed provisions of the False Claims Act, administrative remedies, State laws pertaining to civil or criminal penalties and *qui tam* provisions through the mandatory corporate compliance training.
4. The Chief Compliance Officer (the "CCO") in consultation with the General Counsel and other Legal Counsel as needed has responsibility for receiving and acting upon all information suggesting the existence of possible fraud, abuse or wrongdoing; and for directing all investigations arising from this information.

Procedures:

1. All employees will receive education relating to the provisions of the FCA and the Act during the annual compliance program training.
2. This education will include:
 - Detailed information on the FCA, the Act, and the other administrative remedies for false claims and statements
 - State laws pertaining to civil or criminal penalties
 - Whistleblower rights
 - VistaCare provisions for preventing, detecting and reporting fraud, waste and abuse.
3. All employees, contractors and agents with knowledge of potential fraud and abuse situations must report them through any of the following methods, as applicable:
 - Notifying their supervisor, another managerial employee, a People Department representative, the General Counsel or executive management;
 - Contacting the Chief Compliance Office directly either in person or by phone; or
 - Calling the confidential Hotline 1-866-872-6498 (Toll free in the U.S.).
4. Anyone receiving a report of fraud (e.g., management, People, Legal, etc.) should immediately inform the CCO before any action is taken. No supervisor or manager should directly confront an employee with the allegation of fraud or otherwise discuss the issue with anyone suspected of engaging in fraudulent or abusive practices without prior approval from the CCO.

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5. It is the responsibility of the CCO to direct or conduct fraud and abuse investigations. In conducting an investigation of wrongdoing, facts should be gathered as promptly as possible.
6. The CCO is responsible for detecting potential incidents of fraud and abuse and determining when incidents should be reported to an appropriate law enforcement agency. This position is responsible for ensuring the design and development of methods for identifying fraud and abuse and responding appropriately and immediately to all detected program violations. If incidents of fraud and abuse are identified, systematic changes and corrective action initiatives will be put into place as appropriate to prevent further offenses.
7. The CCO must establish and maintain methods for detecting and preventing incidents of fraud and abuse, including but not limited to a claims quality assurance program that monitors the accuracy of claims, a compliance hotline and a process that identifies employees, contractors, vendors and providers that are debarred or excluded from participating in federal programs.
8. Complaints, allegations, and concerns reported through the "Hotline" and/or received directly by the Chief Compliance Office concerning fraud and abuse will be handled under direction and coordination of the CCO.
9. In the case where the allegation is a criminal violation of law, the CCO will confer with internal or outside legal counsel as needed for determination as to whether there is sufficient evidence to support referral to a duly authorized law enforcement agency.
10. To the extent practical or allowed by law, the CCO must maintain the confidentiality or anonymity of an employee or other individual reporting questionable activity when requested.
11. VistaCare will fully cooperate with federal and state agencies that conduct healthcare fraud and abuse investigations.
12. VistaCare will take appropriate disciplinary and enforcement action (i.e., corrective action plans, employment termination or contract termination) against employees, providers, subcontractors, consultants, and agents found to have committed fraud and abuse violations.
13. Retaliation or retribution for reporting issues "in good faith" is prohibited.

Reference Authority/Citations:

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

Federal Program Fraud Civil Remedies Act of 1986, 38 U.S.C. §3801 *et seq.*

United States. Cong. Senate. 109th Congress, 2nd Session. S. 1932, An Act to Provide for Reconciliation Pursuant to Section 202(a) of the Concurrent Resolution on the Budget for Fiscal Year 2006. 109th Congress. GPO Access. 3 January 2006 <<http://thomas.loc.gov>>.