Combating Fraud, Waste & Abuse; Ability to Report Wrongdoing for Federal & Georgia Beneficiaries

PURPOSE

It is the policy of Shepherd Center to obey the law and and eliminate fraud, waste and abuse with respect to payments to Shepherd Center from any organization (specifically including federal and/or state health care programs) providing payment for patient care or services. This policy applies to all employees, management, contractors and agents of Shepherd Center.

This policy and the information contained in it shall be made available to all current and new employees and to all current and future contractors of Shepherd Center.

This policy includes information concerning tools federal and state agencies use to fight fraud, waste and abuse in the administration of federal and state health programs at Shepherd Center: Specifically, this policy addresses the following:

A. A summary of the Federal False Claims Act

B. A summary of administrative remedies found in the Program Fraud Civil Remedies Act

C. A summary of laws of the state of Georgia addressing fraud and abuse and training requirements on policies and procedures.

D. The role of such laws in preventing and detecting fraud, waste, and abuse in federal and state health care programs

E. Shepherd Center's existing policies and procedures for detecting and preventing fraud.

I. Federal Law

A. **The Federal False Claims Act**

Summary of Provisions: The Federal False Claims Act (FCA) prohibits knowingly making a false claim against the government. False claims can take the form of overcharging for a product or service, delivering less than the promised amount or type of service, delivering less than the promised amount or type of goods or services, underpaying money owed to the government and charging for one thing while providing another.

Penalties: The FCA imposes civil penalties and is not a criminal statute. Therefore, no proof of specific intent as required for violation of a criminal statute is necessary.

Persons (including organizations such as hospitals) may be fined a civil penalty of not less than $5,000 nor more than $10,000, plus three (3) times the amount of damages sustained by the government for each false claim. The amount of damages in health care terms is the amount paid for each false claim that is filed.

Qui Tam (Whistleblower) Provisions

Any person may bring an action under this law (called a *qui tam* realtor or whistleblower suit) in federal court. The case is initiated by causing a copy of the complaint and all available relevant evidence to be served on the federal government. The case will remain sealed for at least 60 days and will not be served on the defendant so the government can investigate the complaint. The government may obtain additional time to investigate for good cause. The government on its own

initiative may also initiate a case under the FCA.

After the 60 day period, or any extensions, has expired, the government may pursue the matter in its own name, or decline to proceed. If the government declines to proceed, the person bringing the action has the right to conduct the action on their own in federal court.

If the government proceeds with the case, the *qui tam* relator bringing the action will receive between 15 and 25 percent of any proceeds, depending upon the contributions of the individual to the success of the case. If the government declines to pursue the case, and the *qui tam* realtor successfully prosecutes the claim, the relator will be entitled to between 25 and 30 percent of the proceeds of the case, plus reasonable expenses and attorneys fees and costs.

Any case must be brought within six years of the filing of the false claim.

Non-Retaliation: Anyone initiating a *qui tam* case may not be discriminated or retaliated against in any manner by their employer by virtue of bringing the claim. The employee is authorized under the FCA to initiate court proceedings to make themselves whole for any job related losses resulting from any such discrimination or retaliation.

B. **Program Fraud Civil Remedies Act**

The Program Fraud Civil Remedies Act creates administrative remedies for making false claims separate from, and in addition to, the judicial or court remedy for false claims provided by the Civil False Claims Act.

The Act is quite similar to the Civil False Claims Act in many respects, but is somewhat broader and more detailed, with differing penalties. The Act deals with submission of improper "claims" or "written statements" to a federal agency.

- Specifically, a person violates this act if they know or have reason to know they are submitting a claim that is
    - False, fictitious or fraudulent; or,
    - Includes or is supported by written statements that are false, fictitious or fraudulent; or,
    - Includes or is supported by a written statement that omits a material fact; the statement is false, fictitious or fraudulent as a result of the omission; and the person submitting the statement has a duty to include the omitted facts; or
    - For payment for property or services not provided as claimed.

  A violation of this prohibition carries a $5,000 civil penalty for each such wrongfully filed claim. In addition, an assessment of two times the amount of the claim may be made, unless the claim has not actually been paid.
- A person also violates this act if they submit a written statement which they know or should know:
    - Asserts a material fact which is false, fictitious or fraudulent; or,
    - Omits a material fact and is false, fictitious or fraudulent as a result of the omission. In this situation, there must be a duty to include the fact and the statement submitted contains a certification of the accuracy or truthfulness of the statement.

  A violation of the prohibition for submitting an improper statement carries a civil penalty of up to $5,000.

II. Georgia Law

A. Georgia Anti-Fraud Law and Training Requirements Related to Health Care

1. O.C.G.A 49-4-146.1. Unlawful to obtain benefits and payments under certain circumstances; penalties; procedures

This Georgia statute can be described as Georgia's Medicaid Unlawful Payment Statute. Only part of the statute is included in this policy.

O.C.G.A. 49-4-146.1 (b) provides that it shall be unlawful:

a. For any person or provider to obtain, attempt to obtain, or retain for himself, herself, or any other person any **medical assistance or other benefits or payments under this article, or under a managed care program operated, funded, or reimbursed by the Georgia Medicaid program,** to which the person or provider is not entitled, or in an amount greater than that to which the person or provider is entitled, when the assistance, benefit, or payment is obtained, attempted to be obtained, or retained, by:

   i. Knowingly and willfully making a **false statement or false representation;**

   ii. Deliberate **concealment of any material fact;** or

   iii. Any **fraudulent scheme or device;** or

b. For any person or provider knowingly and willfully to **accept medical assistance payments to which he or she is not entitled or in an amount greater than that to which he or she is entitled, or knowingly and willfully to falsify any report or document** required under this article.

Any person violating paragraph (1) or (2) shall be **guilty of a felony** and, upon conviction thereof, shall be punished for each offense by a fine of not more than $ 10,000.00, or by imprisonment for not less than one year nor more than ten years, or by both such fine and imprisonment. The statute is a criminal statute and, the state has the burden of proving beyond a reasonable doubt that the defendant intentionally committed the acts for which he or she is charged. In addition to criminal penalties, any person committing abuse shall be liable for a **civil monetary penalty** equal to two times the amount of any excess benefit or payment.

"'Abuse' is defined in the statute as a provider knowingly obtaining or attempting to obtain medical assistance or other benefits or payments under this article to which the provider knows he or she is not entitled .... and the assistance, benefits, or payments directly or indirectly result in unnecessary costs to the medical assistance program." Isolated instances of unintentional errors in billing, coding, and costs reports shall not constitute abuse. **Miscoding shall not constitute abuse if there is a good faith basis** that the codes used were appropriate under the department's policies and procedures manual and there was no deceptive intent on the part of the provider.

In addition to any other penalties provided by law, each person violating this law shall be liable for a **civil penalty equal** to the greater of (1) three times the amount of any such excess benefit or payment or (2) $ 1,000.00 for each excessive claim. Additionally, interest on the penalty shall be paid at the rate of 12 percent per annum.

2. Georgia has a **Patient Self Referral Act** which, while similar to the federal Stark law in some ways, is significantly different in terms of when it applies and to whom it applies. It can be found at **O.C.G.A. § 43-1B-1.** It is not included in this policy since it addresses financial arrangements and investment interest issues by physicians.
3. **GA ADC 290-9-7-.12. Human Resources Management.**
   Georgia hospital licensing regulations require hospitals to train its employees on the hospital's policies and procedures. Specifically, GA ADC 290-9-7.12 pertains to Personnel training programs. The hospital shall have and implement a planned program of training for personnel to include at least:
   a. Hospital policies and procedures;
   b. Fire safety, hazardous materials handling and disposal, and disaster preparedness;
   c. Policies and procedures for maintaining patients' medical records;
   d. The infection control program and procedures; and
   e. The updating of job-specific skills or knowledge.
4. **GA ADC 290-9-7-.41. Enforcement of Rules and Regulations.**
   Georgia's hospital licensing regulations also contains enforcement provisions. GA ADC 290-9-7.41 provides "A hospital that fails to comply with these rules and regulations shall be subject to sanctions and/or permit revocation as provided by law. The enforcement and administration of these rules and regulations shall be as prescribed in the Rules and Regulations for Enforcement of Licensing Requirements, Chapter 290-1-6, pursuant to O.C.G.A. Sec. 31-2-6."

III. Role in Preventing and Detecting Fraud, Waste & Abuse in Federal and State Health Care Programs

The laws described in this policy create a comprehensive process for controlling fraud, waste and abuse in federal and state health care programs by giving appropriate governmental agencies the authority to seek out, investigate and prosecute violations. Enforcement activities are pursued in three available forums: criminal, civil and administrative. This provides a broad spectrum of remedies to address the fraud and abuse problem.

Moreover, whistleblower protections, such as those included in the federal False Claims Act, provide protections for individuals reporting fraud and abuse in good faith.

IV. Shepherd Center's Policies for Detecting and Preventing Fraud

All policies and procedures relating to fraud and abuse (Business Ethics & Compliance Program) are available to all employees in the Shepherd Center intranet-based policy and procedure manual database.

Any business ethics concerns may be reported through the chain of command or to the Compliance Hotline [(800) 860-0085]. Reports made to the Compliance Hotline may be done so on an anonymous basis.