POLICY TITLE: Obligations of Agents and Contractors Relative to False Claims Act and other laws

APPLICATION: This policy is adopted for and applies to HealthEast St. John’s Hospital, HealthEast St. Joseph’s Hospital, HealthEast Woodwinds Hospital, HealthEast Bethesda Hospital, HealthEast Clinics and all other HealthEast Care System facilities.

PURPOSE: To comply with the Deficit Reduction Act of 2005 regarding establishing written policies for contractors and agents of HealthEast that provide detailed information about federal and state False Claims Acts and the Program Fraud Civil Remedies Act of 1986 and penalties and protections under such laws. To make compliance and fraud, waste, and abuse awareness training available to contractors and agents of HealthEast.

POLICY: HealthEast expects each of its contractors and agents to comply with federal and state false claims acts and other laws applicable to HealthEast’s or the agent/contractor’s business, and expects its contractors and agents to educate their employees on such laws. Solely for the purposes of this policy, contractors and agents include HealthEast Medical Staff.

PROCEDURE: HealthEast shall act as a resource to its contractors and agents by providing contractors and agents with detailed information about federal and state False Claims Acts and the Acts’ penalties and protections, and other applicable health care laws. This policy and Exhibit A to this policy shall be available to any contractor/agent upon its request. This policy and Exhibit A shall also be available at www.healtheast.org/suppliers. Exhibit A is made part of this policy and may be amended from time to time to reflect then current information regarding federal and state laws.

Effective Date: October 19, 2006

Authorized by: President and Chief Executive Officer

Source/Submitted by: LaVonne Wieland, HealthEast Compliance Officer


Unit and Department Distribution List:

Other HealthEast Policy Reference: 106-9 HealthEast Organizational Principles and Compliance Program

STP:138902.1
EXHIBIT A

DEFICIT REDUCTION ACT INFORMATION

HealthEast Care System and its affiliates (“HealthEast”) is proud of its commitment and leadership in operating an effective compliance program to detect and prevent fraud, waste and abuse in federal and state health care programs. As part of its program, HealthEast has developed various policies and procedures, including a policy entitled Obligations of Agents and Contractors Relative to False Claims Act and Other Laws. That policy and HealthEast’s Code of Conduct, Compliance Manual and related policies are designed to create a culture of compliance and enable HealthEast to prevent and detect instances of fraud, waste or abuse in federal and state health care programs through ensuring that persons have knowledge and resources necessary to act lawfully and by monitoring activities to ensure compliance. Further policy information may be obtained by contacting the HealthEast compliance department. HealthEast expects that activities conducted by it and its contractors and agents will be conducted in compliance with all laws and regulations. If anyone has knowledge of any inappropriate activity, such activity should be reported to HealthEast immediately.

The following is a summary of laws designed to detect and prevent fraud, waste and abuse in federal health care programs. HealthEast expects that its contractors and agents will educate their employees on the following:

Federal False Claims Act
The federal false claims act applies to the submission of claims for payment from government programs, such as the Medicare and Medicaid programs.

The federal False Claims Act prohibits, among other things, any person from:

(A) knowingly presenting, or causing to be presented, a false or fraudulent claim for payment or approval under any Federal Programs for items and services;

(B) knowingly making, using, or causing to be made or used, a false record or statement material to a false or fraudulent claim;

(C) conspiring to defraud the government by getting a false or fraudulent claim allowed or paid;

(D) having possession, custody or control of property or money used or to be used by the government and knowingly delivering less than all of such money or property; and

(E) knowingly making or using, or causing to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the government or knowingly concealing, avoiding or decreasing an obligation to pay or transmit money or property to the government.

A violation of the False Claims Act could result in a penalty of up to $11,000, plus 3 times the amount of damages sustained by the government because of the false or fraudulent claim.

A person acts knowingly if the person has actual knowledge, acts in deliberate ignorance of the truth or falsity, or acts in reckless disregard of the truth or falsity of the information.
Copies of the False Claims Act may be obtained from the HealthEast compliance department or HealthEast legal counsel.

The United States Attorney General may bring civil actions for violations of the Federal False Claims Act. The False Claims Act also permits private individuals to bring whistleblower actions for violations of the act. HealthEast policy and the False Claims Act prohibit retaliation against employees who exercise such rights.

**Program Fraud Civil Remedies Act of 1986**
The Program Fraud Civil Remedies Act of 1986 (PFCRA) authorizes federal agencies such as the Department of Health and Human Services ("DHHS") to investigate and assess penalties for the submission of false claims to the agency. The conduct prohibited by the PFCRA is similar to that prohibited by the federal False Claims Act. For example, a person may be liable for making, presenting, or submitting, or causing to be made, presented, or submitted, a claim that the person knows or has reason to know:

(A) is false, fictitious, or fraudulent;

(B) includes or is supported by any written statement which asserts a material fact which is false, fictitious, or fraudulent;

(C) includes or is supported by any written statement that –
   
   (i) omits a material fact;
   
   (ii) is false, fictitious, or fraudulent as a result of such omission; and
   
   (iii) is a statement in which the person making, presenting, or submitting such statement has a duty to include such material fact; or

(D) is for payment for the provision of property or services which the person has not provided as claimed.

If a government agency suspects that a false claim has been submitted, it can appoint an investigating official to review the matter. The investigating official may issue a subpoena to further the investigation, or may refer the matter to the Department of Justice for proceedings under the federal False Claims Act.

**The Anti-Kickback Statute**
In general, the Anti-Kickback Statute prohibits:

- Knowing and willful solicitations or receipt of remuneration in return for referring an individual or purchasing a type of service, or
- Knowing and willful offers or payments of remuneration to refer an individual or for purchasing a type of service for which a federal health care program may pay.

Certain transactions that would otherwise be prohibited are allowed under specified “Safe Harbors.” The prohibition applies to both parties in the arrangement. Both civil and criminal penalties may be applied. Criminal penalties include up to five years in prison plus $25,000 in fines. Civil penalties include up to $50,000 in fines and three times the lost dollar amount.
Self-Referral Prohibition Statute (Stark Law)
The federal Stark prohibits a physician who has (or whose immediate family member has) a financial relationship with an entity from making a referral to the entity for the furnishing of certain designated health services, including, but not limited to, inpatient and outpatient hospital services, for which payment otherwise may be made by Medicare or Medicaid, unless an exception to the Stark law is satisfied. The Stark law also prohibits the entity from submitting a claim to Medicare or Medicaid for reimbursement or billing any individual, third party payor or other entity for the designated health services furnished pursuant to a prohibited referral, unless an exception to the Stark law is satisfied.

Minnesota Law
Minnesota law (Minn. Stat. § 15C.01 et seq.) has a state False Claims Act which is similar to the federal False Claims Act. The state False Claims Act imposes a civil penalty of up to $11,000 per false or fraudulent claim, plus 3 times the amount of damages sustained by the state or political subdivision, on persons who engage in any of the conduct that is prohibited by the federal False Claims Act but against the state or a political subdivision (directly or indirectly).

Actions that are merely negligent, inadvertent or mistaken are not subject to the state civil penalty.

In addition, Minnesota law (Minn. Stat. § 609.465) provides that whoever, with the intent to defraud, presents a claim or demand, with knowledge that it is false in whole or in part, for audit, allowance or payment to a public officer or body authorized to make such audit, allowance or payment is guilty of an attempt to commit theft of public funds and may be sentenced accordingly.

Furthermore, Minnesota law (Minn. Stat. § 609.466) provides that whoever, with the intent to defraud, presents a claim for reimbursement, a cost report or a rate application, relating to the payment of medical assistance funds which is false in whole or in part, is guilty of an attempt to commit theft of public funds and may be sentenced accordingly.

State law protects employees who report, in good faith, a suspected violation of a law to an employer, government body or law enforcement official, from retaliation.

COMPLIANCE AND FRAUD, WASTE AND ABUSE AWARENESS TRAINING

Medicare Advantage, Medicare Part D, and Medicaid Managed Care Plans
HealthEast provides health care services to individuals enrolled in Medicare Advantage (“MA”), and Medicare Part D Prescription Drug (“Part D Plan”) plans and Medicaid managed care plans. Medicaid managed care organizations and MA and Part D Plan sponsors, such as Medica Health Plan and Blue Cross and Blue Shield of Minnesota, are required to implement effective compliance programs to prevent, detect and correct fraud, waste, and abuse and noncompliance with Centers for Medicare and Medicaid (“CMS”) and Minnesota Department of Human Services (“DHS”) program requirements. The purpose of a compliance program is to prevent, detect and correct noncompliance with CMS and DHS program requirements and instances of fraud, waste and abuse. Examples of noncompliance with CMS and DHS program requirements include not cooperating with CMS or DHS auditors, untimely submission of data to CMS or DHS, and violating member privacy.
An effective compliance program includes the following elements:

1. Written standards of conduct and policies and procedures that describe the organization’s commitment to comply with all federal and state standards; provide guidance to employees and others on dealing with potential compliance issues; describe expectations as embodied in the standards of conduct; and are easily accessible to vendors and providers;
2. Designation of a Compliance Officer and Committee that is accountable to senior management, employed by the organization, periodically reports to the governing body, and responsible for oversight of the compliance program;
3. Annual training and education that is provided to employees, the governing body, and entities providing services to Medicare and Medicaid members;
4. Effective lines of communication between the Compliance Officer, Compliance Committee, employees, managers and governing body that maintain confidentiality and allow anonymity if desired and that are available to entities that provide administrative or health services to Medicare and Medicaid members;
5. Well-publicized disciplinary standards that articulate expectations for reporting compliance issues and assist in their resolution; provide for timely, consistent, and effective enforcement of the standards when non-compliance or unethical behavior is determined; and encourage good faith participation in the compliance program;
6. Routine monitoring and identification of risks by conducting internal monitoring and auditing; obtaining external audits when appropriate; auditing and monitoring entities that provide administrative or health services to Medicare and Medicaid members; and evaluation of overall effectiveness of the compliance program; and
7. A system for prompt response to issues that acknowledges issues as they are raised; requires appropriate investigation of potential compliance problems; corrects such problems promptly and thoroughly to reduce the potential for recurrence; and includes procedures to voluntarily self report potential fraud or misconduct to CMS or its designee or to DHS.

The HealthEast Compliance Program

It is HealthEast’s policy to comply consistently and fully with all laws and regulations governing HealthEast’s business, including laws and regulations that apply to HealthEast because of its participation in Medicare, Medicaid and other government programs. In furtherance and support of this policy, HealthEast has implemented the HealthEast Compliance Program. The HealthEast Compliance Program includes all elements of an effective compliance program described above.

The HealthEast Compliance Program is made up of a number of components, including, but not limited to, the HealthEast Code of Conduct which communicates HealthEast’s expectations for compliant and ethical behavior, the HealthEast Compliance Manual which serves as a resource regarding the structure and expectations of the HealthEast Compliance Program, and HealthEast Compliance Policies which describe the expectations or procedures relating to specific compliance areas.

HealthEast employs a system Compliance Officer who carries out the day to day activities of the HealthEast Compliance Program and is available to act as a resource to any person regarding laws, regulations, policies or the HealthEast Code of Conduct. HealthEast also has a Compliance Committee to provide guidance to the HealthEast Compliance Officer and oversight of the HealthEast Compliance Program. The HealthEast Board of Directors provides oversight to the HealthEast Compliance Program and matters pertaining to compliance. A critical aspect of the HealthEast Compliance Program is effective communication and training on the HealthEast
Compliance Program, Code of Conduct, policies, and laws and regulations governing HealthEast’s business.

Additional information regarding the HealthEast Compliance Program can be obtained from the HealthEast Compliance Officer.

**Reporting Compliance Concerns**

All contractors and agents who do business with HealthEast are expected to comply with all laws and regulations that govern HealthEast’s business when providing services to or on behalf of HealthEast. Any person who believes that HealthEast or any individual is violating laws, regulations or the HealthEast Code of Conduct must immediately report his or her concerns to the HealthEast Compliance Officer (651) 232-6442. Failure to report suspected or known violations will be cause for corrective action, including dismissal or contract termination. If you are uncomfortable contacting the HealthEast Compliance Officer directly, you may call the confidential **HealthEast Compliance Hotline at (651) 232-5420** or contact HealthEast legal counsel at (612) 305-7699.