SUBJECT: Employee Education about False Claims Recovery (Deficit Reduction Act of 2005)
POLICY NUMBER: _____
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GENERATED BY: Integrity-Compliance Office

SCOPE. This policy covers all employees of Covenant Health and those Covenant Health subsidiaries involved in furnishing Medicaid items or services (collectively referenced as "Covenant" in this policy) and the employees of Covenant contractors and agents who perform billing and coding functions or who, on behalf of Covenant, furnish or authorize the furnishing of Medicaid health care items or services or are involved in monitoring of health care provided by Covenant ("Contractors and Agents").

PURPOSE. To comply with the education requirements set forth in Section 6032 of the Deficit Reduction Act of 2005.

POLICY. It is the policy of Covenant to provide its employees with detailed information regarding Covenant's policies and procedures for detecting and preventing fraud, waste, and abuse. Further, it is the policy of Covenant to provide detailed information regarding the federal and state false claims laws to its employees, and to Covenant Contractors and Agents for the benefit of their employees, with respect to the role of such laws in preventing and detecting fraud, waste and abuse in federal health care programs.

1. Detecting and Preventing Fraud, Waste, and Abuse. Covenant is strongly committed to detecting and preventing fraud, waste, and abuse. To this end, Covenant has adopted an active integrity-compliance program and operates under a code of conduct. The Covenant compliance program requires compliance with both legal requirements and ethical standards and is composed of the following key elements:

(i) Support for the program comes from the highest levels of the organization.
(ii) A Corporate Compliance Officer leads Covenant's compliance efforts.
(iii) A Code of Conduct sets forth Covenant's expectations concerning compliant behavior and there are policies and procedures that support the compliance effort and address key compliance areas.
(iv) The program provides for safe, secure, and confidential reporting mechanisms for reporting of employee concerns (anonymously, if requested) and to seek guidance on compliance issues.
(v) The program provides for training employees, contractors, and related parties on the elements of the program.
(vi) there is an effective system of internal controls to monitor compliance efforts.
(vii) The program calls for an on-going compliance risk assessment and annual assessment and renewal of the compliance program.

All Covenant employees and Contractors and Agents are required to act in a manner consistent with the requirements of the Covenant Health integrity-compliance program and to review the Covenant Code of Conduct issued by the Covenant Health Integrity-Compliance Office, the principles and requirements of which apply to all dealings with Covenant. Should any Covenant employee, or any Contractor or Agent (or employee of the same), obtain information that reasonably leads it, him, or her to believe there has or may have been a violation of law or of Covenant's compliance program by Covenant or any of its employees, Contractor, or Agents, such person must promptly report and disclose the same to the Covenant Health Integrity-Compliance Office and provide such office with all information related to such belief. Such person also must cooperate with the Integrity-Compliance Office in any audit or investigation instituted by Covenant related to any compliance matters or other actions taken pursuant to Covenant's compliance program. Covenant prohibits any form of retaliatory conduct or action against any employee or person who reports any compliance violation or concern pursuant to the program.

[Covenant DRA Policy 6.26.07]

The Covenant Health Integrity-Compliance Office has a toll-free hotline (1-888-731-3115) for compliance reporting. In addition, concerns maybe reported via an internet connection. Any report maybe made anonymously, if desired. All reports to the Integrity-Compliance Office are treated as confidential to the greatest extent possible. Further, all forms of information received, transmitted, discussed, or archived by the Integrity-Compliance Office, including but not limited to, verbal and written communications, documents, reports, correspondence, network transmissions, and electronically or magnetically stored data are treated as confidential.

2. False Claims Laws. State and federal false claims laws combat fraud and abuse in governmental health care programs, including Medicare, Medicaid, and TennCare. False claims laws do this by making it possible for the government to bring civil actions to recover damages and penalties when false claims are submitted. These laws often permit "qui tam relator" suits, which are lawsuits brought by private (i.e., nongovernmental) parties. The federal False Claims Act ("FCA") provides, in pertinent part, that:

> (a) Any person who (1) knowingly presents, or causes to be presented, to an officer or employee of the United States Government or a member of the Armed Forces of the United States a false or fraudulent claim for payment or approval; (2) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; (3) conspires to defraud the Government by getting a false or fraudulent claim paid or approved by the Government;... or (7) knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government,
> * * *
> is liable to the United States Government for a civil penalty of not less than $5,000 and not more than $10,000, plus 3 times the amount of damages which the Government sustains because of the act of that person ... .31 U.S.C. § 3729.

The Tennessee Medicaid False Claims Act provides, in pertinent part, that:

> Any person who: (1)(A) presents, or causes to be presented, to the state a claim for payment under the Medicaid program knowing such claim is false or fraudulent; (B) makes, uses, or causes to be made or used, a record or statement to get a false or fraudulent claim under the Medicaid program paid for or approved by the state knowing such record or statement is false; (C) conspires to defraud the state by getting a claim allowed or paid under the Medicaid program knowing such claim is false or fraudulent; or (D) makes, uses, or causes to be made or used, a record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the state, relative to the Medicaid program, knowing such record or statement is false; is liable to the state for a civil penalty of not less than five thousand dollars ($5,000) and not more than twenty-five thousand dollars ($25,000), plus three (3) times the amount of damages which the state sustains because of the act of that person. Tenn. Code Ann. § 71-5-182.

The North Carolina Medical Assistance Provider False Claims Act provides, in pertinent part, that:

> It shall be unlawful for any provider of medical assistance under the Medical Assistance Program [Medicaid] to: (1) knowingly present, or cause to be presented to the Medical Assistance Program a false or fraudulent claim for payment or approval; or (2) knowingly make, use, or cause to be made or used a false record or statement to get a false or fraudulent claim paid or approved by the Medical Assistance Program. Each claim presented or caused to be presented in violation of this section is a separate violation.
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> [A] court shall assess against any provider of medical assistance under the Medical Assistance Program who violates this section a civil penalty of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000) plus three times the amount of damages which the Medicaid

> Assistance Program sustained because of the act of the provider… In addition to the damages and penalty assessed by the court…,a provider violating this section shall also be liable for the costs of a civil action brought to recover any penalty or damages, interest ion the damages…, and the costs of the investigation. N.C. Gen. Stat. § 108A-70.12

For purposes of these false claims laws, "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. While these false claims laws impose liability only when the claimant acts "knowingly," they do not require that the person submitting the claim have actual knowledge that the claim is false, and no proof of specific intent to defraud is required. A person who acts in "reckless disregard" or in "deliberate ignorance" of the truth or falsity of the information also can be found liable under the laws. In sum, the false claims laws impose liability on any person who submits a claim to the federal government or to the state Medicaid program (including TennCare) when the person knows (or should know) the claim is false. An example may be a physician who submits a bill to Medicare for medical services he/she knows has not been provided.

The false claims laws also impose liability on an individual who may knowingly submit a false record in order to obtain payment from the government. An example of this may include a government contractor who submits records that he/she knows (or should know) are false and that indicate compliance with certain contractual or regulatory requirements.

The third area of liability includes those instances in which someone may obtain money from the federal government or the TennCare program to which he may not be entitled, and then uses false statements or records in order to retain the money. An example of this so-called "reverse false claim" may include a hospital who obtains interim payments from Medicare throughout the year, and then knowingly files a false cost report at the end of the year in order to avoid making a refund to the Medicare program.

The State of Tennessee imposes criminal penalties in connection with false claims and statements when a person—which includes enrollees, recipients, applicants, vendors, and providers—obtains, or helps another person obtain, "by means for a willfully false statement, representation, or impersonation, or by concealment of any material fact, or by any other fraudulent means, or in any manner not authorized by any rule, regulation, or statute governing TennCare," medical assistance benefits provided by the TennCare program. This includes providing information that would result in a person obtaining greater benefits than those to which they are entitled, or paying a lower monthly premium than that which they would otherwise be required to pay. These criminal penalties also apply when any person provides false information regarding a claim or a person's medical condition that could result in the TennCare program paying a greater amount than it would otherwise have paid. Tenn. Code Ann. § 71-5-2601.

There also are federal and state administrative remedies for false claims and statements. These remedies may be imposed by a governmental agency as an administrative matter, after a hearing. Remedies include civil monetary penalties ranging form $5,000 to $25,000 per false claim, and double or treble damages. 42 U.S.C. § 3802; Tenn. Code Ann. § 71-5-182.

In addition to their substantive provisions, the federal and Tennessee false claims laws provide that private parties may bring an action on behalf of the government. These private parties are known as "qui tam relators." The purpose of bringing the suit is to recover the funds paid by the governmental health program as a result of the false claims. Sometimes the government decides to join the suit. If the suit is ultimately successful, the relator who initially brought the suit may be awarded a percentage of the funds recovered. Subject to some exceptions and depending on the facts of the situation, including whether the relator contributes substantially to the prosecution and whether the government intervenes in the suit, a qui tam relator may receive between 15 and 30 percent of the proceeds of the false claims act action. However, a court may reduce the qui tam relator's share of the proceeds if the court finds that the relator planned and initiated the false claims violation. Further, if the relator is convicted of criminal conduct related to his or her role in the preparation or submission of the false claims, the whistleblower may be dismissed from the civil action without receiving any portion of the proceeds. Also, if the government does not intervene in the action, the defendant prevails, and the court finds that the claim of the individual bringing the action was clearly frivolous, clearly vexatious, or brought primarily for the purposes of harassment, a court may award the defendant its reasonable attorney fees and expenses.

The federal and Tennessee false claims laws contain provisions that protect a qui tam relator from retaliation by his or her employer, and the North Carolina false claims law contains similar provisions that protect employees who cooperate with the state in either an investigation or a lawsuit. These provisions apply to any employee who is discharged, demoted, suspended, threatened, harassed, or in any other way discriminated by his/her employer in the terms and conditions of employment as a result of the employee's lawful acts in furtherance of a false claims action. Remedies include reinstatement with comparable seniority, 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.

3. Contractor and Agent Responsibilities. Contractors and Agents must abide by this policy as to the work the Contractor or Agent performs for Covenant and make this policy available to their employees who are involved in performing that work.

4. Covenant Responsibilities. Covenant Health shall ensure that this policy is available to all employees, including management. Covenant Health shall ensure that all Contractors and Agents: (1) are provided with this policy, (2) disseminate the same to their employees, and (3) agree to abide by the same as to the work the Contractor or Agent performs for Covenant. Further, Covenant shall include the substance of this policy in any employee handbook or equivalent document. The Covenant Integrity-Compliance Office will include this policy in its compliance training of Covenant employees.

5. Definitions. For purposes of this policy, the term "Contractors and Agents" includes any contractor, subcontractor, agent, or other person that, on behalf of Covenant, furnishes or authorizes the furnishing of Medicaid health care items or services, performs billing or coding functions, or is involved in the monitoring of health care provided by Covenant. Contractors and Agents that furnish Medicaid health care items and services include, without limitation, all contract therapists, physicians (including, but not limited to, house staff, hospitalists, and independent contractors), pharmacies, and supply vendors (even if the contract with the supply vendor has not been reduced to a writing). "Contractors and Agents" do not include individuals, businesses, or organizations that perform functions not associated with the provision of Medicaid health care items or services, such as copy or shredding services, grounds maintenance, and hospital cafeteria or gift shop services.