CAPITAL REGION MEDICAL CENTER
ADMINISTRATIVE POLICY MANUAL

TITLE:	**Fraud & Wrongdoing Reporting**	**ARTICLE:**	5
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PURPOSE
The purpose of this policy is to provide information about combating waste, fraud and abuse and the ability of employees to report wrongdoing.

POLICY
It is the policy of Capital Region Medical Center to obey the law and to work to stop and eliminate waste fraud and abuse with respect to payments to Capital Region Medical Center from federal or state programs providing payment for patient care. This policy applies to all employees, management, contractors and agents of Capital Region Medical Center.

This policy and the information contained in it shall be distributed to all current and new employees and to all current and future contractors of Capital Region Medical Center. This policy is included in the Administrative Manual of Capital Region Medical Center.

This policy includes the following information concerning tools this organization, federal and state agencies and individuals use to fight fraud, waste and abuse in the administration of federal and state health programs at Capital Region Medical Center:

- A summary of the Federal False Claims Act
- A summary of administrative remedies found in the Program Fraud Civil Remedies Act
- A summary of laws of the state of Missouri that impose civil or criminal penalties for false claims or statements
- A summary of protections for employees (whistleblowers) who report suspected violations of these federal and state laws.
- The role of such laws in preventing and detecting fraud, waste, and abuse in federal and state health care programs
- Capital Region Medical Center's existing policies and procedures for detecting and preventing fraud

A detailed description of the forgoing points follows:

- **The Federal False Claims Act**
  The Federal False Claims Act (FCA) was first enacted during the Civil War to fight fraud in supplying goods to the Union Army. The law has undergone a number of changes since then and now applies to any federally funded contract or program, except tax fraud. The FCA was expanded to include Medicare and Medicaid programs in 1986.

  Summary of Provisions: The 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 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* relator pursues the case, the *qui tam* relator will be entitled to between 25 and 30 percent of the proceeds of the case, plus reasonable expenses and attorneys fees and costs awarded against the defendant.

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

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

- **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 and improper statement carries a civil penalty of up to $5,000.

- **Missouri Anti-Fraud Laws Related to Health Care**
  Health Care Payment Fraud and Abuse (§§191.900 – 191.910 RSMo)

  The Missouri General Assembly has enacted statutes directed at prosecuting Medicaid fraud. The statutes carry both civil and criminal penalties. Because violation of the statutes can be criminal in nature, the element of intent is required. This is a higher standard than found in the two federal statutes discussed, above, which require only that a person knew or should have known they were committing a violation. There are no whistleblower protections contained in this particular set of statutes. However, whistleblower protections contained in other Missouri statutes would apply to reporting of violations of this statute. These protections are described elsewhere in this policy.

  The acts proscribed by state statute fall into two categories: direct fraudulent conduct and conduct related to improper remuneration in exchange for referrals or purchasing of "health care." "Health care" is defined very broadly to include all health care services and products. The statute addresses two types of conduct – direct fraud and kickbacks.

  - **Direct Fraud** — §191.905.1 RSMo prohibits:
    - Knowingly presenting a claim for payment that falsely states the health care provided was medically necessary.
    - Knowingly concealing an event affecting initial or continued payments by a medical assistance program for providing care.
    - Knowingly concealing or failing to disclose any information in order to obtain a payment from a medical assistance program to which the health care provider is not entitled or improperly increasing the amount of any such payment to which the health car provider is entitled.
    - Knowingly making a claim for payment for health care that was provided that has a lesser value than the amount of the claim.

  - **Anti-Referral (antikickback)** -- §191.905.2 RSMo parallels the federal Medicare antikickback statute. The state statute prohibits knowingly offering or paying, or soliciting or receiving in any manner whatsoever, remuneration (anything of value) in exchange for referring another person for health care services or for purchasing or furnishing of health care. The statute provides for an exception for discounts that are properly disclosed and accounted for in cost reports and for remuneration paid to employees. The statute also incorporates the safe harbors provided for in federal regulations as additional exceptions.

- **Whistleblower Protections**
  "Whistleblowers" are generally employees who observe activities or behavior that may violate the law in some manner. These individuals report their observations either to management or to governmental agencies. Laws have been enacted to protect these individuals. Protections afforded to *qui tam* relaters are discussed, above, under the section describing the federal Civil False Claims Act.

Missouri law requires hospitals to have policies, filed with the Department of Health and Senior Services, that:
- Prohibit any supervisor with power to hire and fire an employee from preventing an employee from making reports described below;
- Prohibit any supervisor with power to hire or fire from using their authority from discriminating against, retaliating against, dismissing or in any manner penalizing any employee making reports described below; and
- Establishes a program to identify a compliance officer responsible for administering the reporting and investigation process making reports described below. An alternative person to do this must be identified if the primary individual is implicated in any report.

The forgoing protections apply to any employee who in good faith reports
- alleged facility mismanagement or fraudulent activity;
- alleged violations of federal or state laws or administrative rules regarding patient care, patient safety; or ,
- The ability of employees to successfully perform their assigned duties.

Employees wishing to make a report to a governmental agency other than the Missouri Department of Health and Senior Services, which is responsible for hospital licensure, must first make the report to the person designated by the hospital to administer this process. In addition, provision must be made to allow the employee to remain anonymous, as well as safeguarding not only the confidentiality of the employee, but also of patients, the integrity of data and medical record information. An employee making a report must be notified within 48 hours of receipt of a report by the hospital that the report has been received and is being reviewed.

Missouri hospital licensure regulations administered by the Missouri Department of Health and Senior Services (DHSS) also protect employees of licensed hospitals who report mismanagement or violations of applicable laws and rules. Each licensed hospital must have a policy that, at a minimum, provides:
- that no supervisor or person with hiring or firing authority shall prohibit employees from discussing hospital operations with DHSS representatives; and,
- that no supervisor or person with hiring or firing authority shall prohibit an employee from disclosing information which the employee reasonably believes violates state or federal law

However, these requirements shall are not meant to:
- permit an employee to leave their assigned work area during normal working hours without following applicable policies and procedures;
- authorize an employee to represent their views as those of their employer; or
- preclude an employer from taking appropriate disciplinary actions against and employee

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

  The laws described in this policy create a comprehensive scheme for controlling waste, fraud 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 battle this problem.

  Moreover, whistleblower statutes and protections for individuals reporting waste fraud and abuse in good faith encourage reporting of waste fraud and abuse, creating broader opportunities to prosecute violators. Whistleblower statutes, such as the federal Civil False Claims Act and found in Missouri law, create reasonable incentives for this purpose. Employment protections create a level of security

employees need to help in prosecuting these cases.

- **Capital Region Medical Center's existing policies and procedures for detecting and preventing fraud**
  See also the Capital Region Medical Center Corporate Compliance Plan which contains additional policies for detecting and preventing fraud. The hospital's Corporate Compliance Plan may be found out on the employee's support website **"The Region"**.

  The process for employees to make complaints to management may be found in the Corporate Compliance Plan under Developing Effective Lines of Communication or completing the Inquiry/Report Form and mailing to the hospital's Corporate Compliance Officer or CRMC Legal Counsel.