"Creating Life Opportunities"

Policy and Procedure # 692

Washington False Claims Statutes Policy

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POLICY: Company affiliates who are Medicare or Medicaid providers in Washington or provide services to Washington Medicare or Medicaid providers must ensure that all employees, including management, and any contractors or agents are educated regarding the federal and State false claims statutes and the role of such laws in preventing and detecting fraud, waste, and abuse in federal health care programs.

FALSE CLAIMS LAWS

One of the primary purposes of false claims laws is to combat fraud and abuse in government health care programs. False claims laws do this by making it possible for the government to bring civil actions to recover damages and penalties when healthcare providers submit false claims. These laws often permit qui tam suits as well, which are lawsuits brought by lay people, typically employees or former employees of healthcare facilities that submit false claims. There is a federal False Claims Act. Washington has adopted a similar false claims act that contains qui tam and whistleblower protection provisions that are similar to those found in the federal False Claims Act. Additionally, Washington has adopted a generally applicable Medicaid antifraud statute that is intended to prevent the submission of false and fraudulent claims to the California Medicaid program.

FEDERAL FALSE CLAIMS LAWS

Under the federal False Claims Act, any person or entity that knowingly submits a false or fraudulent claim for payment of United States Government funds, or knowingly retains an overpayment of such funds more than 60 days, is liable for significant penalties and fines. The fines include a penalty of up to three times the Government's damages, civil penalties ranging from $10,957 to $21,916 per false claim, as adjusted by the Federal Civil Penalties Inflation Adjustment Act of 1990, plus the costs of the civil action against the entity that submitted the false claims. Generally, the federal False Claims Act applies to any federally funded program. The federal False Claims Act applies, for example, to claims submitted by healthcare providers to Medicare or Medicaid.

One of the unique aspects of the federal False Claims Act is the "qui tam" provision, commonly referred to as the "whistleblower" provision. This provision allows a private person with knowledge of a false claim to bring a civil action on behalf of the United States Government to recover the funds paid by the Government as a result of the false claim. If the suit is ultimately successful, the whistleblower who initially brought the suit may be awarded a percentage of the funds recovered. In addition, the United States Government may elect to join the qui tam suit. In this case, if the suit is

successful, the percentage of the funds awarded to the whistleblower is lower because the Government will take over the expenses of the suit. However, regardless of whether the Government participates in the lawsuit, the court may reduce the whistleblower's share of the proceeds if the court finds that the whistleblower planned and initiated the false claims violation. Further, if the whistleblower is convicted of criminal conduct related to his role in the false claim, the whistleblower will be dismissed from the civil action without receiving any portion of the proceeds.

The federal False Claims Act also contains a provision that protects a whistleblower from retaliation by his or her employer. This applies to any employee who is discharged, demoted, suspended, threatened, harassed, or discriminated against in his or her employment as a result of the employee's lawful acts in furtherance of a false claims action. The whistleblower may bring an action in the appropriate federal district court and is entitled to reinstatement with the same seniority status, 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's fees.

A similar federal law is the Program Fraud Civil Remedies Act of 1986 (the "PFCRA"). It provides administrative remedies for knowingly submitting false claims and statements. A false claim or statement includes submitting a claim or making a written statement that is for services that were not provided, or that asserts a material fact that is false, or that omits a material fact. A violation of the PFCRA results in a maximum civil penalty of $5,000 per claim plus an assessment of up to twice the amount of each false or fraudulent claim.

WASHINGTON MEDICAID FALSE CLAIMS ACT

Under Washington's Medicaid False Claims Act (the "WMFCA"), any person who (1) knowingly presents, or causes to be presented, 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 material to a false or fraudulent claim; (3) is authorized to make or deliver a document certifying receipt of property used, or to be used, by the government entity and, intending to defraud a government entity, makes or delivers the receipt without completely knowing that the information on the receipt is true; (4) knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the government entity, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the government entity; or (5) conspires to commit one or more of the above listed violations. *See* RCW 74.66.020.

A violator will be liable to the State for three times the amount of damages sustained by the State and attributable to the violator, plus a civil penalty of at least $5,500 but no more than $11,000. The violator shall also be liable to the Attorney General for the costs of a civil action brought to recover such damages. Certain liabilities may be reduced if the violator furnishes the Attorney General with all information known to the violator within thirty (30) days of receiving such information, provided that the

violator does not have knowledge of an investigation at the time the violator furnishes such information. *See* RCW 74.66.020.

The Washington Attorney General shall investigate suspected violations of the WMFCA and may bring civil action against a person that has violated the WMFCA. An individual may also bring a private civil action on behalf of the individual and the State. In the event the qui tam action is successful, the individual bringing the civil action may be awarded a percentage of the funds recovered. *See* RCW 74.66.050, 060.

Whistleblower Protections

The WMFCA contains an employee protection provision that prohibits an employer from discharging, demoting, suspending, threatening, harassing, or otherwise discriminating against an employee, contractor, or agent for lawfully disclosing information regarding a false claims action against the employer.

Such relief under WMFCA's whistleblower protections include, but are not limited to, the following: reinstatement with the same seniority status as if the discrimination had not occurred, twice the amount of back pay, interest on the back pay and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorney's fees. *See* RCW 74.66.090.

WASHINGTON MEDICAID ANTIFRAUD STATUTE

Washington also prohibits certain fraudulent activities in connection with any Washington health care benefit program, including Medicaid. Washington's antifraud law prohibits a person from obtaining or attempting to obtain payments in excess of the amount to which such person is entitled by means of willful false statements, misrepresentation, concealment of material facts, misrepresentation of items billed, or willfully billing for purportedly covered items which were in fact not covered by Washington's Medicaid program. Any person that violates this section must repay the amounts wrongfully obtained plus interest and may be subject to a civil penalty in an amount up to three times the amount of the excess payment received. *See* RCW 74.09.210.

Whistleblower Protections

Washington's antifraud law also contains an employee protection provision that prohibits an employer allowing any workplace reprisal or retaliatory action against an employee who in good faith reports a violation of Washington's Medicaid antifraud provision. Retaliatory action includes denying adequate staff to fulfill duties, causing frequent staff changes, causing frequent and undesirable office changes,

refusing to assign meaningful work, causing an unwarranted and unsubstantiated report of misconduct, causing unwarranted and unsubstantiated letters of reprimand or unsatisfactory performance evaluations, demoting, reducing pay, denying promotion, suspending, dismissing, denying employment, a supervisor or superior behaving in or encouraging coworkers to behave in a hostile manner toward the whistleblower, a change in the physical location of the employee's workplace, or a change in the basic nature of the employee's job. An employer who violates this employee protection provision may be liable to the affected employee for restoration of benefits, back pay, and any increases in compensation that would have occurred, all with interest. Such employer may also be subject to a civil penalty of up to $5,000. The identity of a whistleblower who complains, in good faith, to the authorities about a suspected violation of the Medicaid antifraud provision may remain confidential if requested. *See* RCW 74.09.315.

ADDITIONAL WASHINGTON FALSE CLAIMS STATUTES

Additional false claims provisions prohibit any person from (1) knowingly making or causing to be made any false statement or false representation of a material fact in any application for payment under any state health care benefit program; (2) at any time knowingly making or causing to be made any false statement or representation of a material fact for use in determining rights to such payment, or knowingly falsifying or concealing a material fact in connection with such application for payment, or (3) knowingly concealing the occurrence of any event affecting a person's right to have payment made for a health care service with the intent to obtain a health care payment to which the person or any other person is not entitled or in an amount greater than that which the person or any other person is entitled. Each violation of this provision is a class C felony, provided that any fine imposed will not exceed $25,000. *See* RCW 74.09.230, 48.80.030.

REPORTING CONCERNS REGARDING FRAUD, ABUSE, AND FALSE CLAIMS

The Company takes issues regarding false claims and fraud and abuse seriously. The Company encourages all employees, management, and contractors or agents of the Company's affiliated facilities to be aware of the laws regarding fraud and abuse and false claims and to identify and resolve any issues immediately. Issues are resolved fastest and most effectively when given prompt attention at the local level. Therefore, the Company encourages its affiliated facilities' employees, managers, and contractors to report concerns to their immediate supervisor when appropriate. If the supervisor is not deemed to be the appropriate contact or if the supervisor fails to respond quickly and appropriately to the concern, then the individual with the concern should be encouraged to discuss the situation with the Company's human resources manager, the Company's ECO, another member of management, or with the Company's Ethics Hotline (1-800-455-1996).

Employees, including management, and any contractors or agents of Company-affiliated facilities

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should be aware of related facility policies regarding detection and prevention of health care fraud and abuse. These policies and procedures can be accessed on Atlas, the Company's Intranet site, or the Company website at www.hcahealthcare.com. The following are some of the policies that are relevant to this policy and to the prevention and detection of fraud and abuse: (1) EC.025 - Reporting Compliance Issues and Occurrences to the Corporate Office Policy; (2) REGS.GEN.015 - Correction of Errors Related to Federal and State Healthcare Program FFS Reimbursement Policy; and (3) RB.009 - Reporting of Cost Report Overpayment Policy. Note that employees, contractors, and agents of Exceptional Foresters Inc. providing services to other, non-affiliated facilities should also understand that all such facilities are expected to have similar policies applying to contractors (including the Company) requiring (1) compliance with federal and state laws, including false claims laws; (2) reporting of potential overpayments and compliance concerns; and (3) the whistleblower protections described above.

DEFINITION:

The contractor or **agent** includes any contractor, subcontractor, agent, or other person which or who, on behalf of the facility, furnishes, or otherwise authorizes the furnishing of Medicaid health care items or services, performs billing or coding functions, or is involved in monitoring of health care provided by the facility.

PROCEDURE:

Company responsibilities include, but are not limited to:

a. Ensuring that all employees, including management, and any contractors or agents of the facility, are provided with this policy, within 30 days of commencing employment or contractor status.
b. Ensuring that the Company handbook includes a detailed summary of this policy.

Revising this policy as necessary to comply with changes in the law. Changes must be documented and implemented. When policies and procedures are revised, the previous versions of the policies and procedures must be retained for ten (10) years.

REFERENCES:

- **RCW 74.66.995 et seq.**
- **RCW 48.80.010 et seq.**
- **RCW 74.09.210, 230, 260, 315**
- **31 U.S.C. §§ 3801-3812**
- **31 U.S.C. §§ 3729-3733**

Deficit Reduction Act of 2005, Sections 6031, 6032