Policy

State Addendums to Code of Ethical Conduct – Ohio					
Date Implemented:	09/18/2020	*Date Reviewed/ Revised:*	01/01/2022	*Reviewed/ Revised By:*	PHC

OHIO STATE FALSE CLAIMS ACT

SCOPE: This is a supplement to the Code of Ethical Conduct and Employee Handbooks for employees who work in Ohio. As stated in our handbooks, the federal False Claims Act and similar state laws assist the federal and state governments in combating fraud and recovering losses resulting from fraud in government programs, purchases and/or contracts. This applies to all employees and contractors or agents of Company located in the state of Ohio, including, but not limited to, all facilities, and all Corporate Departments, Regions, and Markets.

PURPOSE: To comply with certain requirements set forth in the Deficit Reduction Act of 2005 with regard to federal and state false claims laws.

POLICY: Management of facilities that are Medicare or Medicaid providers in Ohio 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, that 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.

FEDERAL FALSE CLAIMS LAWS

Originally enacted in 1865 by Congress, the federal Civil False Claims Act, 31 U.S.C. § 3729, *et seq.* ("FCA"), uncovered several instances of fraud among defense contractors during the Civil War. President Abraham Lincoln wanted this legislation during the Civil War to address widespread abuse by military contractors who were selling defective products and materials to the Union Army and charging excessively high prices for their services.

The current FCA, which was amended in 1986, provides the government with authority to identify and recover monies paid out fraudulently. The government has had billions of dollars returned to it because of the current FCA. Corporations and individuals have, either through litigation or settlement, returned monies or paid fines because of allegations of improperly obtaining federal health care program finds. FCA is a proven means to detect fraud, by encouraging individuals, called whistleblowers" or "relators," to uncover and report fraud to the government.

FCA PROHIBITIONS

The federal FCA prohibits any individual or entity from knowingly submitting false or fraudulent claims, causing submission of such claims, making a false record or statement in order to secure payment from the federal government for such a claim, or conspiring to get coverage for such a claim so it is paid. Under the statute the terms "knowing" and "knowingly" mean that a person:

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.

Two examples of activities prohibited by the FCA are knowingly billing for services that the beneficiary did not receive, and knowingly upcoding treatments provided to beneficiaries. Upcoding is the practice of billing for a more highly reimbursed service or product than the one provided.

PENALTIES

Individuals or entities violating the FCA may be liable for a civil penalty for each false claim of not less than $5,500 and not more than $11,000, plus up to three times the amount of damages sustained by the federal government.

QUI TAM & WHISTLEBLOWER PROTECTION PROVISIONS

The United States Attorney General, under the FCA, may bring actions alleging violations by individuals and entities. The FCA allows private citizens to file a lawsuit in the name of the United States for false or fraudulent claims submitted by individuals or entities that do business with or receive reimbursement from the United States. These lawsuits have another name, which is *qui tam* action. A qui tam action, or lawsuit brought under the FCA by a private citizen begins when that citizen files a civil complaint in federal court, under seal, and service of a disclosure of material evidence occurs on the United States Attorney General. The United States Attorney General must within sixty days investigate the allegations in the qui tam lawsuit and decide whether it will join in the lawsuit. If the United States Attorney General joins in the lawsuit, the federal court will unseal the complaint. In addition, the government through either the Department of Justice or the local United States Attorney's Office may prosecute the lawsuit. If the government decides not to join in the lawsuit, the whistleblower may pursue the lawsuit alone. Sometimes the government will join in the lawsuit later, if there is a good reason for doing so.

The federal government may collect up to three times the amount of money that the individual or entity billed or received in error. The government may also collect a fine for each claim or case of fraud. The whistleblower receives a monetary reward that is a percentage collected by the government because of the lawsuit. This amount ranges between 15% and 25% of the dollars that the government recovers during its investigation and settlement/litigation. As an incentive to bring these cases, the FCA provides that whistleblowers who file a *qui tam* action may receive a reward of 15-30% of the monies recovered for the government, plus attorneys' fees and costs. The court may reduce this award, if for example the court finds the whistleblower planned and initiated the violation. The FCA also provides that "whistleblowers" who bring lawsuits that are clearly frivolous are liable for the individual or entities' cost for defending the lawsuit, including its attorneys' fees. The FCA provides certain protections for whistleblowers against retaliation for bringing a qui tam action or lawsuit under the Act. Employers discharging, demoting, discriminating, or harassing whistleblowers because of the lawsuit may also be liable to make the

employee whole, which could include reinstatement, double back pay, and compensation for any special damages including litigation costs and reasonable attorneys' fees. Further, if there is a criminal conviction of the whistleblower related to his role in the preparation or submission of the false claims, the Court may dismiss the whistleblower from the civil action without receiving any portion of the proceeds.

FEDERAL PROGRAM FRAUD CIVIL REMEDIES ACT

The Program Fraud Civil Remedies Act of 1986 ("PFCRA"), provides for administrative remedies (fines) against persons who make, or cause to be made, a false claim or written statement to certain federal agencies, including the Department of Health and Human Services ("HHS"). The goal of PFCRA is to lower the amount of dollars diverted by fraud, and generally applies to claims of $150,000 or less. PFCRA provides that any person who makes, presents or submits, or causes to be made, presented, or submitted a claim that the person knows or has reason to know is false, fictitious, or fraudulent is subject to civil money penalties of up to $5,000 per false claim or statement and up to twice the amount claimed in lieu of damages. The HHS Office of the Inspector General investigates and enforces PFCRA actions, which must have the approval of the United States Attorney General prior to going forward against the person. PFCRA enforcement can begin with a hearing before an administrative law judge. Recovering the penalties may be through a civil action brought by the Attorney General or through an administrative offset against "clean" or correct claims.

OHIO MEDICAID ANTI-FRAUD STATUTES

Ohio laws impose liability on providers or persons who commit fraud in the Ohio medical assistance program. Ohio's Medicaid fraud laws, specifically, O.R.C. §§ 2913.40, 2921.13, and 5111.03, prohibit providers from making false or misleading statements in order to receive payment for goods or services provided to Medicaid beneficiaries that is greater than the amount of reimbursement to which they are entitled. These laws prohibit, among other things:

- Billing Ohio's Medicaid program for services or goods not provided;
- Billing Ohio's Medicaid program for undocumented services;
- Making inaccurate, false or improper entries in medical records, cost reports and any other records used to support reimbursement;
- Billing Ohio's Medicaid program for medically unnecessary services;
- Characterizing non-covered services or costs in a way that secures reimbursement from Ohio's Medicaid program;
- Assigning an incorrect code to a service in order to obtain a higher reimbursement;
- Failing to seek payment from beneficiaries who may have other primary payment sources;
- Participating in kickbacks and rebates;
- Altering, falsifying, destroying, or concealing medical records, income and expenditure reports or any other records that support Medicaid reimbursement.

The Ohio laws, specifically O.R.C. § 2913.401, also prohibit any person from doing any of the following in an application for Medicaid benefits or in a document that requires a disclosure of assets for the purpose of determining eligibility to receive Medicaid benefits:

- Making or causing to be made a false or misleading statement; or
- Concealing an interest in property.

CIVIL AND CRIMINAL PENALTIES FOR FALSE CLAIMS OR STATEMENTS

A violation of these Ohio laws may result in penalties of $5,000 to $10,000 for each falsification, three times the amount unlawfully received plus interest, payment of the government's expenses to pursue reimbursement, and exclusion from the Medicaid program for up to five years. In addition, a person who

violates these laws commits a crime punishable by imprisonment for up to five years and a fine not to exceed $10,000.

CIVIL LAWSUITS

Currently, unlike the Federal False Claims Act, Ohio law allows civil lawsuits to recover monetary damages to be filed only by the state government and not by private citizens or employees. There is no provision for a private citizen to share a percentage of any monetary recoveries.

NO RETALIATION

Like federal law, Ohio law prohibits employers from retaliating, discriminating or harassing employees because of their lawful participation in a false claims disclosure or their refusal to assist employers in violating laws such as the Ohio Medicaid fraud laws. These laws also provide for certain monetary awards and equitable relief to the prevailing plaintiff including compensation for lost wages and reinstatement to a former position.

Ohio's whistleblower law, unlike other laws, requires an employee to notify his/her employer, both orally and in writing of any suspected illegal activity, policy or practice before disclosing it to the appropriate government agency. The purpose of this particular requirement is to give the employer a reasonable opportunity to correct the activity, policy or practice. If the employer does not make a good faith effort to correct the asserted violation within 24 hours of receiving notice, the employee may file a written report of the violation with the county prosecuting attorney, law enforcement, any governmental entity that has regulatory authority over the employer or the inspector general.

Any employee who engages in or condones any form of retaliation against another employee because that employee either (1) reported a potential violation of the Code of Ethical Conduct or a government law or regulation, or (2) refused to violate the Code of Ethical Conduct or a government law or regulation, will be subject to disciplinary action up to and including separation of employment. For additional guidance, please see the Employee Handbook and Code of Ethical Conduct.

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, Facility Compliance Officer, another member of management, or with the Company's Compliance Hotline (1-877-531-7472).

Employees, including management, and any contractors or agents of Company-affiliated facilities 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 the Company's Intranet site. The following are some of the policies that are relevant to this policy and to the prevention and detection of fraud and abuse: (1) Confidential Disclosure Program; (2) Employee Grievance Procedure; (3) Open Door Policy; (4) Reporting Noncompliance to the CEO; (5) Medicare Overpayment and Credit Balance Reporting; (6) Whistleblower Protections; (7) Billing for Services; (8) Regulatory Compliance; and (9) Personal

Policy

Obligation to Report Violations. Note that employees, contractors, and agents of Business Associates providing services to 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:

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 Medicare or 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.
c. 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:

1. Medicaid eligibility fraud, ORC §§2307.65, 2913.401; (3) Whistleblower laws, ORC §§4113.51 to 4113.53 (private employees) and §124.34.1 (government employees
2. Ohio Medicaid False Claims Act
3. O.R.C. §§ 2913.40, 2921.13, and 5111.03, 2913.40, 2921.13, and 109.85; 4113.51 to 4113.53 and 124.34.1
4. Whistleblower laws
5. 31 U.S.C. §§ 3801-3812
6. 31 U.S.C. §§ 3729-3733
7. Deficit Reduction Act of 2005, §§ 6031, 6032
8. Code of Ethical Conduct
9. Employee Handbook