False Claims Act Policy

A. Prevention and Detection of Fraud, Abuse, and Waste

Intercommunity Home Health Care (IHHC) has a longstanding practice of fair and truthful dealing with its participants, their families, the government, health professionals and other business associates. No IHHC Associate shall engage in any act of fraud, abuse or waste, such as knowingly making false statements of material fact, in the preparation or submission of any claim for reimbursement under the Medicaid program. A IHHC Associate is any IHHC worker, Representative, Representative worker, contractor or other agent hired by IHHC. Compliance with this Policy is a condition of employment or business relationship with IHHC. Violation of this policy is grounds for immediate termination of employment or agency relationship.

The federal Deficit Reduction Act of 2005 ("DRA"), effective January 1, 2007, was enacted to bring entitlement spending under control by increasing the detection and prevention of fraud, waste and abuse. DRA requires Medicaid providers like IHHC to implement formal written policies to combat such fraud, abuse and waste. DRA imposes liability on any person who knowingly, directly or indirectly, is involved in presenting a false or fraudulent claim to the U.S. government for payment. DRA also provides special protections for workers who report any such suspected or actual wrongdoing. This Appendix will describe IHHC' anti-fraud policies and procedures and the specific federal and Minnesota laws relating to fraud, abuse and waste.

Fraud is an intentional misrepresentation that, when relied on by a payer or other person, deceives that person to his or her detriment. Abusive tactics are broader than fraud, and may include submitting deceptive or misleading claims to a government program like Medicaid, or using a false statement to support a claim. Waste may include other deceptive tactics, such as over-utilization of otherwise necessary
services.

Types of fraud, abuse, or waste which may lead to liability are:

1. Knowingly filing a false or fraudulent claim for payments to Medicare, Medicaid or another governmentally funded health care program, such as billing for services not actually provided;
2. Knowingly making or using a false record or statement to obtain payment on a false or fraudulent claim from Medicare, Medicaid or other governmental program, such as documenting clinical care not actually provided;
3. Conspiring to defraud Medicare, Medicaid or other governmentally funded health care program by attempting to have a false or fraudulent claim paid; or
4. Knowingly making or using, or causing to be made or used, a false record to statement to conceal, avoid or decrease an obligation to pay or transmit money or property to the government.

Examples of the above include but are not limited to:

a. Billing for services not actually provided;
b. Making payments to a phantom vendor or phantom worker;
c. Paying a vendor or worker for services not actually provided;
d. Paying an invoice known to be false;
e. Accepting or soliciting kickbacks or illegal inducements from vendors of services, or offering or paying kickbacks or illegal inducements to vendors of services;
f. Paying, offering gifts, money, remuneration or free services to entice a Medicaid recipient to use a particular vendor;
g. Using Medicaid reimbursement to pay a personal expense;
h. Embezzling; and
i. Ordering and charging for medical services not necessary for the participant.

"Knowingly" means that a person (i) has actual knowledge of the information, (ii) acts in deliberate ignorance of the truth or falsity of the information, or (iii) acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required.

B. Mandatory Reporting Requirement.

If any IHHC Associate has reason to believe that anyone associated with IHHC has engaged in any fraud, abuse or waste, the Associate has a duty to report any such observations and concerns immediately to the Executive Director. IHHC shall not retaliate against anyone submitting a timely report pursuant to this policy.

All reports shall be investigated under the supervision of the Executive Director. All Associates have a duty to cooperate with any investigation conducted by IHHC under this requirement, including but not limited to providing information upon request and meeting with IHHC' legal, accounting or other authorized representatives, if directed to do so by the Executive Director.

IHHC will take any necessary action to respond appropriately to any substantiated offense and to prevent any further offenses, including but not limited to terminating IHHC workers, Representative relationships and contractor or agency contracts. Offenses will be evaluated for voluntary self-disclosure under applicable federal laws, and when warranted, they will be referred to federal and state authorities. IHHC will cooperate with government officials investigating or prosecuting any individual referred by IHHC.

C. Federal and State Laws.

(i) False Claims Act.

Federal law requires Medicaid providers like IHHC to provide you with detailed information about the administrative remedies under the federal False Claims Act, 31 U.S.C. §§ 3729-3733 and 3801-3812. These laws are important to you and IHHC because they not only provide severe sanctions for submitting false claims to the federal Medicaid program, they also provide whistleblower protections to individuals who alert federal and state officials to offenses.

Under the False Claims Act, individuals or organizations that are found to have knowingly submitted false claims to the federal government, including the Medicaid program, are subject to civil liability in the amount of $5,500 to $11,000 per claim, plus three times the amount of damages the government sustained because of the illegal act. Offenders also face exclusion from the Medicaid and Medicare programs. Penalties may be reduced for providers who promptly self-disclose suspected False Claims Act violations if the information is submitted within
30 days of learning of it, if the organization fully cooperates with the government's investigation of the violation and depending on whether the government has already begun its own investigation of the reported violation.

(ii) Program Fraud Civil Remedies Act.

Under the Program Fraud Civil Remedies Act of 1986, a separate law similar to the False Claims Act, a civil money penalty of up to $5,500 per false claim or false statement relating to a claim may be imposed, as well as damages equal to twice the amount of any reimbursed false claim. Investigations may be commenced by the Secretary of Health and Human Services for claims submitted that a person knows are false,
that include any written statement that includes a material misstatement of fact or omits a material fact that the person has a duty to disclose
or that is in payment for property or services not provided.

(iii) Minnesota Medical Assistance Fraud Laws.

In addition to the sanctions levied by federal law, Minnesota law contains criminal and civil penalties for Medical Assistance fraud. Under
Minn. Stat. § 609.466, any person who, with the intent to defraud, presents a claim for reimbursement which is false in whole or in part is guilty of an attempt to commit theft of public funds and may be sentenced accordingly. Under Minn. Stat. § 256B.121, any vendor of medical care who willfully submits a claim for reimbursement that is known to be a false claim is also subject to a civil action by the State of Minnesota for three times the payments which result from the false representation, costs and attorneys' fees.

(iv) Minnesota Vulnerable Adult Law.

Subjecting a vulnerable adult to unnecessary and over-utilized services for the profit or advantage of another may also constitute financial exploitation under the Minnesota Vulnerable Adults Act, Minn. Stat. §§626.5572, subd. 9 and 609.2335.

(v) Whistleblower Protections under federal and Minnesota Law.

The federal False Claims Act, at 31 U.S.C. §3730(h), provides anti-retaliation protections for whistle-blowing workers. If an worker participates in the investigation for, initiation of, testimony for, or assistance in an action filed under the False Claims Act, the employer may not discharge, demote, suspend, threaten, harass or in any other manner discriminate against the worker in the terms and conditions of employment, in retaliation for the worker's protected action.
Relief for an worker who is retaliated against in violation of 31 U.S.C. §3730(h) may include

reinstatement, double back pay with interest, and compensation for any special damages, including litigation costs and reasonable attorneys' fees. In addition, the False Claims Act enables private individuals to initiate lawsuits on behalf of the federal government against any party who submitted false claims for payment from the Medicaid program. Known as *qui tam* actions, the suing private plaintiff, if successful, may be rewarded part of any penalty recovered and the remainder goes to the government. Depending upon the circumstances of each case, the government may intervene. In cases where the government declines to intervene and the private plaintiff pursues the action on his or her own, the plaintiff's recovery share may be as great as 25 to 30% of the penalty. In cases where the government elects to intervene, the court may award between 15 and 25% of the recovery to the private plaintiff. Individuals who initiate *qui tam* cases may not be discriminated or retaliated against in any manner by their employers. Employer violations of the *qui tam* anti-retaliation provisions could result in reinstatement and damages of double the amount of lost wages if the worker is fired and any other damages sustained if the worker is otherwise discriminated against.

The Minnesota Whistleblower Law, Minn. Stat. §181.932, prohibits employers from discharging, disciplining, threatening or otherwise discriminating against or penalizing an worker for good faith reporting of suspected violations of any state or federal law or rule, or for participating in a government investigation. The law allows workers to refuse an employer's order to perform an act that violates federal or state law. The Minnesota law expressly authorizes a worker to report in good faith violations of federal or state health care standards that put the public at risk.

D. IHHC Fraud Prevention and Detection Policy.

IHHC has adopted Policies and Procedures for Maintaining Program Integrity by Preventing Fraud, Abuse and Other Wasteful Financial Practices (Attachment 1). These Policies and Procedures describe IHHC' internal efforts to maintain the integrity of our billing and reimbursement policies, as well as the process for reporting and investigation of fraud, waste and abuse. It is a condition of every Associate's employment or agency relationship with IHHC that both this Policy and the False Claims Policy be read, understand and complied with. Anyone with questions about this policy or who desires to report a suspected False Claims Act or other fraud-related violation should immediately contact the Executive Director. Anyone who feels retaliated against under the whistleblower and qui tam protections of the laws, as described above, should immediately contact the Executive Director or any member of the Board. IHHC reserves the right to amend or terminate this Policy as applicable laws or circumstances require.

Intercommunity
Home Health Care

Acknowledgement of Receipt

As the Worker, I have reviewed the above policy in the Manual. I understand that Intercommunity Home Health Care requires that I be trained on the rights of consumers and duties of workers related to the use and disclosure of protected health information. I agree to comply with all policies and procedures. I understand that severe civil and criminal penalties (up to ten years imprisonment and a $250,000 fine) may be imposed for violation of these regulations.

Worker Signature: _____

Date:

Representative Signature: _____

Date:

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