

VIRTUA HEALTH FRAUD AND ABUSE PREVENTION POLICY

POLICY

It is the policy of Virtua Health to obey all federal and state laws, to implement and enforce procedures to detect and prevent fraud, waste and abuse regarding payments to Virtua Health from federal or state healthcare programs, and to provide protections for those who report actual or suspected wrongdoing.

PURPOSE

To satisfy the requirements of Section 6032 of the Deficit Reduction Act of 2005, 42 U.S.C. §1396a(a)(68), by setting forth certain federal and state laws relating to liability for false claims and statements; protections against reprisal or retaliation for those who report wrongdoing; and Virtua Health policies and procedures to detect and prevent fraud, waste and abuse.

Explanation of Laws: 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.

Anti-retaliation protections for individuals who make good faith reports of waste, fraud and abuse encourage reporting and provide broader opportunities to prosecute violators. Statutory provisions, such as the anti-retaliation provisions of the Civil False Claims Act, create reasonable incentives for this purpose. Employment protections create a level of security colleagues need to assist with the prosecution of these cases.

Set forth below are summaries of certain statutes that provide liability for false claims and statements and Virtua Health's policies and procedures regarding fraud and abuse. These summaries are not intended to identify all applicable laws, but rather to outline some of the major statutory provisions as required by the Deficit Reduction Act of 2005, 42 U.S.C. §1396a(a)(68).

Federal False Claims Act (31 U.S.C. §§ 3729 – 3733)

The Federal False Claims Act (FCA) imposes civil liability on any person or entity who:

- knowingly files a false or fraudulent claim for payments to Medicare, Medicaid or other federally funded health care programs;
- knowingly uses a false record or statement to obtain payment on a false or fraudulent claim from Medicare, Medicaid or other federally funded health care programs; or
- conspires to defraud Medicare, Medicaid or other federally funded health care program by attempting to have a false or fraudulent claim paid.

“Knowingly” means:

- actual knowledge that the information on the claim is false;
 - acting in deliberate ignorance of whether the claim is true or false; or
 - acting in reckless disregard of whether the claim is true or false.
- It requires no proof of specific intent to defraud.

A person or entity found liable under the FCA is subject to a civil money penalty of between \$13,508 and \$27,018 plus three times the amount of damages that the government sustained because of the illegal act. In health care cases, the amount of damages sustained is the amount paid for each false claim that is filed.

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Anyone may bring a *qui tam* action under the FCA in the name of the United States in federal court. The case is initiated by filing the complaint and all available material evidence under seal with the federal court. The complaint remains under seal for at least 60 days and will not be served on the defendant. During this time, the government investigates the complaint. The government may, and often does, obtain additional investigation time by showing good cause. After expiration of the review and investigation period, the government may elect to pursue the case in its own name or decide not to pursue the case. If the government decides not to pursue the case, the person who filed the action has the right to continue with the case on his or her own.

If the government proceeds with the case, the person who filed the action will receive between 15 percent and 25 percent of any recovery if he or she was not involved with the wrongdoing, depending upon the contribution of that person to the prosecution of the case. If the government does not proceed with the case, the person who filed the action can bring a private action/lawsuit, and if successful, is entitled to between 25 percent and 30 percent of any recovery, plus reasonable expenses and attorneys' fees and costs.

Substantive and procedural amendments to the FCA were enacted in 2009 and 2010 in the Fraud Enforcement and Recovery Act of 2009 ("FERA"), the Patient Protection and Affordable Care Act ("PPACA"), and the Dodd-Frank Wall Street Reform and Consumer Protection Act ("Dodd-Frank"). All of these amendments will make it easier for the government and *qui tam* relators to conduct investigations and obtain recoveries under the FCA in the future.

Federal Program Fraud Civil Remedies Act (31 U.S.C. §§ 3801 – 3812)

The Program Fraud and Civil Remedies Act (PFCRA) creates administrative remedies for making false claims and false statements. These penalties are separate from and in addition to any liability that may be imposed under the Federal False Claims Act.

The PFCRA imposes liability on people or entities who file a claim that they know or have reason to know:

- is false, fictitious, or fraudulent; includes or is supported by any written statement that contains false, fictitious, or fraudulent information;
- includes or is supported by a written statement that omits a material fact, which causes the statement to be false, fictitious, or fraudulent, and the person or entity submitting the statement has a duty to include the omitted fact; or
- is for payment for property or services not provided as claimed.

A violation of this section of the PFCRA is punishable by a \$5,000 civil penalty for each wrongfully filed claim, plus an assessment of twice the amount of any unlawful claim that has been paid.

In addition, a person or entity violates the PFCRA if they submit a written statement which they know or should know:

- asserts a material fact that is false, fictitious or fraudulent; or
- omits a material fact that they had a duty to include, the omission caused the statement to be false, fictitious, or fraudulent, and the statement contained a certification of accuracy.

Patient Protection and Affordable Care Act (PPACA: PL 111-148 – MARCH 2010)

The Patient Protection and Affordable Care Act (PPACA) was signed into law by President Obama on March 23, 2010. Among other things, PPACA links the retention of program overpayments to potential liability under the Federal False Claims Act. Failure to report and repay any overpayment within the timeframe may result in a violation of the Federal False Claims Act, civil monetary penalty, or other penalties. Unpaid overpayments are also grounds for program exclusion. Furthermore, states are required to terminate the participation of any individual or entity that has been excluded under any other State plan

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or Medicare. In addition, a claim that includes items or services resulting from a violation of the Anti-Kickback Statute now constitutes a false or fraudulent claim under the Federal False Claims Act.

New Jersey False Claims Act, P.L. 2007, Chapter 265 (N.J.S. 2A:32C-1 et seq)

This law, which was enacted on January 13, 2008 and was effective 60 days after enactment, has three parts: (a) the main part authorizes the NJ Attorney General and whistleblowers to file false claims lawsuits similar to what is authorized under the Federal False Claims Act, and has similar whistleblower protections; (b) another part makes violations of the NJ False Claims Act also give rise to liability under the NJ Medical Assistance and Health Services Act; and (c) a third part amends the NJ Medical Assistance and Health Services Act to increase the civil penalty to the same level provided for under the Federal False Claims Act, currently between \$13,508 and \$27,018 per false claim.

New Jersey Medical Assistance and Health Services Act – Criminal Penalties, N.J.S.A. 30:4D-17(a)-(d)

Provides criminal penalties for individuals and entities engaging in fraud or other criminal violations relating to Title XIX-funded programs. Criminal penalties include: (a) for fraudulent receipt of payments or benefits, (b) false claims, statements or omissions, or conversion of benefits or payments, or (c) kickbacks, rebates and bribes: guilty of a crime in the third degree and no less than \$15,000 and no more than \$25,000. For violations of (a) through (c) above where there has been a prior conviction within 10 years from the date of the current offense, and both the prior conviction and current violation are for amounts that exceed \$1,000 in the aggregate: guilty of a crime in the second degree and no less than \$25,000 and no more than \$150,000 for each repeat violation, and (d) false statements or representations about conditions or operations of an institution or facility to qualify for payments: guilty of a crime in the fourth degree and no less than \$10,000 and no more than \$25,000. Criminal prosecutions are generally handled by the Medicaid Fraud Section within the Office of Insurance Fraud Prosecutor, in the N.J. Division of Criminal Justice.

New Jersey Medical Assistance and Health Services Act – Civil Remedies, N.J.S.A. 30:4D-7(h), N.J.S.A. 30:4D-17(e)-(i); N.J.S.A. 30:4D-17.1(a):

In addition to the criminal sanctions discussed immediately above, violations of N.J.S. 30:4D-17(a)-(d) can also result in the following civil sanctions: (a) unintentional violations: recovery of overpayments and interest; (b) intentional violation, or violation of the New Jersey False Claims Act discussed above: recovery of overpayments, interest, up to triple damages, and an amount not less and not more than the civil monetary penalties currently in effect under the Federal False Claims Act (31 U.S.C. §3729 et seq), discussed above. Recovery actions are generally pursued administratively by the Division of Medical Assistance and Health Services, with the assistance of the Division of Law in the N.J. Attorney General's Office, and can be obtained against any individual or entity responsible for or receiving the benefit or possession of the incorrect payments.

In addition to recovery actions, violations can result in the suspension or exclusion of an individual or entity from participation in all health care programs funded in whole or in part by the N.J. Division of Medical Assistance and Health Services. Recovery and exclusion can also be obtained as part of a criminal prosecution by the Medicaid Fraud Section of the N.J. Division of Criminal Justice.

New Jersey Health Care Claims Fraud Act N.J.S.A. 2C:21-4.2 & 4.3; N.J.S.A. 2C:51-5

Provides for criminal penalties for health care claims fraud, including the submission of false claims to programs funded in whole or in part with state funds by:

- a. A practitioner who knowingly or recklessly commits health care claims fraud in the course of providing professional services is guilty of a crime of the second degree, and is subject to a fine of up to 5 times the monetary benefits obtained or sought to be obtained and to permanent forfeiture of his license;
- b. A person who is not a practitioner subject to paragraph a. above (for example, someone who is not licensed, registered or certified by an appropriate State agency as a health care professional) is guilty of a crime of the third degree if that person knowingly or recklessly commits health care claims fraud.

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New Jersey Conscientious Employee Protection Act, “Whistleblower Act”, N.J.S.A. 34:19-1 et seq.

This “Whistleblower Act” is the NJ law that protects individuals within an organization who observe activities or behavior that may violate the law in some manner and who report their observations either to management or to governmental agencies. You can refer to Virtua Health’s CEPA Notice on the Virtua Colleague Corner under “Compliance Corner”.

Virtua Health’s Corporate Compliance Program and Code of Conduct provides a method for colleagues to report actions or behaviors that violate policies and procedures. Virtua Health strongly encourages colleagues to address questions and concerns through the use of the chain of command. Most situations can be resolved by management. Additionally, a Compliance Hotline is available for colleagues.

New Jersey Insurance Fraud Prevention Act (N.J.S.A. 17:33A-1 et seq.)

The purpose of this act is to confront aggressively the problem of insurance fraud in NJ, by facilitating its detection and eliminating its occurrence through the development of fraud prevention programs. It requires the restitution of fraudulently obtained insurance benefits. Civil penalties may be up to \$5,000 for first violation, \$10,000 for second and \$15,000 for subsequent violations. It also includes a \$1,000 insurance surcharge.

Virtua Health’s Policies and Procedures for Detecting and Preventing Fraud:

Virtua Health’s Corporate Compliance Program establishes and maintains standards through the Code of Conduct and provides a method for colleagues to report actions or behavior that violate our policies or procedures or any violation of law. Virtua Health strongly encourages colleagues to address questions and concerns through the use of the chain of command which is: 1) your supervisor; 2) Another member of management at your facility, 3) Your Human Resources representative. Colleagues can also contact the Corporate Compliance Officer. Additionally, a Compliance Hotline 1-(800) 268-0502 is available for colleagues. Corporate Compliance concerns are kept confidential to the greatest extent possible. Virtua Health will not take any disciplinary action or treat any colleague negatively for using the chain of command or Compliance Office or Hotline to report in good faith any concern. Virtua Health’s Compliance Program policy is located in the Administrative/Leadership Manual, Compliance and at www.virtua.org.

Additionally, employees and vendors can contact the Medicaid Fraud Division Hotline, 888-937-2835, or the NJ Insurance Fraud Prosecutor Hotline, 877-55-FRAUD, to report any violations as noted in this policy.