UC Health

CODE OF CORPORATE COMPLIANCE SUPPLEMENT

January 1, 2007

Purpose

As required by the Deficit Reduction Act of 2005, UC Health supplemented its Code of Corporate Compliance, effective January 1, 2007, to provide the following detailed information to all employees, agents, and contractors about: 1) federal and state False Claims Acts, 2) laws pertaining to civil and criminal penalties for false claims and statements, 3) whistleblower protections under such laws, and 4) UC Health's policies and procedures to detect and prevent fraud, waste, and abuse.

Scope:

This information shall be provided to all employees, and will be made available to agents, and contractors of UC Health.

Detailed Information:

A. Federal False Claims Act

The federal False Claims Act, 31 U.S.C. Sec. 3729-3733, among other things, applies to the submission of claims for payment under any federal program, including claims submitted by health care providers for payment by Medicare, Medicaid, and other federal health care programs. The False Claims Act provides the federal government a civil remedy for fraudulent claims.

The False Claims Act prohibits, among other things:

a) Knowingly presenting or causing to be presented to the federal government a false or fraudulent claim for payment or approval;

b) Knowingly making or using, or causing to be made or used, a false record or statement in order to have a false or fraudulent claim paid or approved by the government;

c) Conspiring to defraud the government by getting a false or fraudulent claim allowed or paid;

d) Knowingly making or using, or causing to be made or used, a false record or statement material to an obligation to pay or transmit money to the government, or knowingly concealing or knowingly and improperly avoiding or decreasing an obligation to pay or transmit money or property to the government; and

e) Knowingly conceals, avoids, or decreases an obligation to pay money to the government.

"Knowingly" means acting with actual knowledge or with reckless disregard or deliberate indifference to the truth or falsity of information.

The United States Attorney General may bring civil actions for violations of the False Claims Act. Penalties under the False Claims Act include three times the amount of any overpayment, and civil monetary penalties of between $5,500 to $11,000 per claim, plus attorneys' fees. The False Claims Act allows private individuals to bring "whistleblower" actions on behalf of the federal government for violations of the Act.

B. Program Fraud Civil Remedies Act of 1986

The Program Fraud Civil Remedies Act of 1986 (PFCRA), 31 U.S.C. Chapter 38, authorizes federal agencies such as the Department of Health and Human Services ("HHS") to investigate and assess penalties for the submission of false claims or statements to the agency. The conduct prohibited by the PFCRA is similar to that prohibited by the False Claims Act. A person may be liable under the PFCRA for making, presenting, or submitting, or causing to be made, presented, or submitted, a claim or statement that the person knows or has reason to know:

a) Is false, fictitious, or fraudulent;

b) Includes or is supported by any written statement which asserts a material fact which is false, fictitious, or fraudulent;

c) Includes or is supported by any written statement that –
    i. Omits a material fact;
    ii. Is false, fictitious, or fraudulent as a result of such omission; and
    iii. Is a statement in which the person making, presenting, or submitting such statement has a duty to include such material fact; or

d) Is for payment for the provision of property or services, which the person has not provided as claimed.

The government agency may assess twice the amount of its damages and a civil penalty of up to $5,500 for each false or fictitious claim. The United States Attorney General has exclusive authority to enforce such assessments and penalties in federal court.

C. State Laws

1) *Ohio Providers.* There also may be liability under Ohio laws for false or fraudulent claims with respect to Medicaid program expenditures, including:

a) Medicaid Fraud, Ohio Revised Code Sec. 2913.40

The Medicaid Fraud Act imposes criminal penalties for among other things:

i. Knowingly making or causing to be made a false or misleading statement or representation for use in obtaining Medicaid reimbursement.

ii. Doing either of the following with the purpose to commit fraud or knowingly facilitating a fraud:

1. charging, soliciting, accepting or receiving any amount in addition to the amount of reimbursement due from Medicaid and any authorized deductibles or co-payments;

2. soliciting, offering or receiving any remuneration other than authorized deductibles and co-payments, in cash or in kind, including kickbacks or rebates, in connection with the furnishing of goods or services for which payment may be made under the Medicaid program.

iii. Knowingly altering, falsifying, destroying concealing or removing any records necessary to support a Medicaid claim or cost report.

b) Medicaid Eligibility Fraud, Ohio Revised Code Sec. 2913.401

The Medicaid Eligibility Fraud Act imposes criminal penalties on persons for knowingly making false or misleading statements, concealing an interest in property, or failing to disclose a transfer of property for purposes of determining eligibility to receive Medicaid benefits.

c) Falsification, Ohio Revised Code Sec. 2921.13

Ohio criminal law prohibits persons from knowingly making false statements or swearing or affirming the truth of a false statement for the purpose of securing payment of benefits administered by a governmental agency or paid out of a public treasury, for the purpose of securing a license, permit, authorization, certification, registration, release, or provider agreement with the government, or in connection with any report that is required or authorized by law, such as the Medicaid cost report.

d) Rights of Employee to Report Violation of Law by Employer, Ohio Revised Code Sec. 4113.52

This Ohio whistleblower law provides protections for employees. The law permits employees to report to their supervisor or other responsible officer of their employer, violations of state or federal statutes or any ordinance or regulation of a political subdivision that the employer has the authority to correct and the employee reasonably believes that the violation either is a criminal offense that is likely to cause an imminent risk of physical harm to persons or a hazard to public health or safety or is a felony. If the employer does not correct the violation, the employee may file a written report of the violation with the prosecuting attorney, law enforcement, inspector general or other governmental entity that has

regulatory authority over the employer. If an employer takes disciplinary or retaliatory action against the employee, the statute permits the employee to file a civil action for reinstatement, payment of back wages, reinstatement of fringe benefits and seniority rights. The court may award the prevailing party the costs of litigation.

e) Offenses by Medicaid Providers, Ohio Revised Code Sec. 5111.03

The Medicaid Provider Offenses Statute prohibits Medicaid providers from acting "by deception" to obtain or receive or attempt to obtain or receive payments to which the provider is not entitled, or to falsify any report or document relating to Medicaid. "Deception" includes acting with reckless disregard or deliberate ignorance of the truth or falsity of information or withholding information. Penalties for violation of the Medicaid Provider Offenses Statute include interest on excess payments, three times the amount of excess payments, civil penalties of $5,000 to $10,000 per false claim, recovery of the costs of enforcement, and termination of the Medicaid provider agreement. The Ohio Attorney General may enforce the provisions of this statute in state court.

f) Disciplinary Actions, Ohio Revised Code Sec. 4731.22

The Physician Disciplinary Actions Statute prohibits physicians and podiatrists from using fraudulent misrepresentation to obtain "money or anything of value" in the course of practice, or otherwise engaging in dishonest, unethical, unprofessional, or criminal conduct as defined in this statute. It also prohibits physicians and podiatrists from waiving deductibles or co-payments as an inducement to keep the patient coming back for care, unless the waiver is approved in writing by the payer. This law enables the Ohio Medical Board to investigate and discipline a physician's license or practice certificate.

g) Prohibiting Referrals for Designated Health Services, Ohio Revised Code Sec. 4731.66

This Medical Practice Act Statute authorizes the Ohio Medical Board to investigate and discipline a physician or podiatrist for referring patients for certain "designated health services" to persons or entities when the provider or a member of the provider's immediate family has an investment interest or compensation arrangement with the person or entity unless the arrangement falls under certain exceptions listed in ORC 4731.67 or 4731.68.

h) Prohibition related to health insurance referrals, Ohio Revised Code Sec. 3999.22

The Ohio insurance code provides that no person shall knowingly solicit, offer, pay, or receive any kickback, bribe, or rebate, directly or indirectly, overtly or covertly, in cash or in kind, in return for referring an individual for the furnishing of health care services or goods for which whole or partial reimbursement is or may be made by a health care insurer, except as authorized by the health care or health insurance contract, policy, or plan, subject to certain exceptions for authorized deductibles and copayments, discounts and bona fide business arrangements. Violation of the statute constitutes a felony.

i) Insurance Fraud, Ohio Revised Code Sec. 2913.47(B)(1)

The elements of Insurance Fraud under the Ohio criminal code are: presenting or causing to present to an insurer, with purpose to defraud or knowing that the person is facilitating a fraud, any written or oral statement that is part of or in support of a claim for payment pursuant to a policy, knowing that the statement, or any part of the statement is false or deceptive. Submission of claims for $1,000 or more, in violation of this statute, constitutes a felony.

2) *Kentucky Providers.* There also may be liability under Kentucky laws for false or fraudulent claims with respect to Medicaid Program expenditures, including:

a) Fraudulent Acts/Penalties, Kentucky Revised Statutes Sec. 205.8463

The Kentucky statute imposes criminal penalties for:

i. Knowingly or wantonly devising or planning a scheme or artifice, or entering into an agreement, combination, or conspiracy to obtain or aid another in obtaining payments from any medical assistance program by means of any fictitious, false, or fraudulent application, claim, report, or document submitted to the Cabinet for Health and Family Services, or intentionally engaging in conduct which advances the scheme.

ii. Intentionally, knowingly, or wantonly making, presenting, or causing to be made or presented to an employee or officer of the Cabinet for Health and Family Services any false, fictitious, or fraudulent statement, representation, or entry in any application, claim, report, or document used in determining the rights to any benefit or payment.

iii. Knowingly making, inducing, or seeking to induce, with the intent to defraud, the making of a false statement or false representation of a material fact with respect to the conditions or operations of an institution or facility in order that the institution or facility may qualify, upon initial certification or upon recertification, as a hospital, skilled-nursing facility, intermediate-care facility, home-health agency, or other provider of services to Kentucky's Medical Assistance Program.

iv. Knowingly falsifying, concealing, or covering up by trick, scheme, or device a material fact, or making any false, fictitious, or fraudulent statement or representation, or making or using any false writing or document knowing the same to contain any false, fictitious, or fraudulent statement or entry.

Under the Kentucky statutes:

"Knowingly" means that a person is aware that his/her conduct is of a certain nature or that a certain circumstance exists.

"Wantonly" means that a person is aware of and consciously disregards a substantial and unjustifiable risk that a particular result will occur or that a particular circumstance exists.

"Intentionally" means that a person's conscious objective is to cause a certain result or to engage in certain conduct.

b) Mandatory Reporting of Violations, Kentucky Revised Statutes Sec. 205.8465

Any person who knows or has reasonable cause to believe that fraud or abuse of the Medicaid program has been or is being committed by any person, corporation, or entity, must report to the Kentucky Medicaid Fraud Control Unit, or the Medicaid Fraud and Abuse hotline, the following information: the name and address of the offender; the offender's place of employment; the nature and extent of the violation; the identity of the complainant; any other information that may be helpful in investigating the alleged fraud and abuse. The identity of the reporting individual will remain confidential. Any individuals reporting under this section are protected by whistleblower protections similar to those found in Section D of this policy.

c) Payment of Penalties for Submission of False Claims, Kentucky Revised Statutes Sec. 205.8467, 205.8469

Penalties for submitting false claims include interest on excess payments, three times the amount of excess payments, civil penalties of $500 per false claim, recovery of legal fees and the costs of investigating and enforcement, and removal from the Medicaid program for 2 to 6 months for a first offense, for 6 months to 1 year for a second offense, and for 1 to 5 years for a third offense. The Kentucky Attorney General may enforce the provisions of this statute.

d) Hotline for Receiving Reports of Fraud and Abuse, Kentucky Revised Statutes Sec. 205.8483

The Office of Inspector General in the Cabinet for Health and Family Services ("OIG") shall establish, maintain, and publicize a 24-hour toll-free hotline for the purpose of receiving reports of alleged fraud and abuse by Medicaid program recipients and participating providers.

e) Prohibited Activities – Commencement of Proceedings for Enforcement, Kentucky Revised Statutes Sec. 194A.505

The Kentucky Attorney General may commence proceedings and impose penalties for, among other things, the following:

i. Knowingly making, with intent to defraud, a false statement or misrepresentation or by other means failing to disclose a material fact used in determining the person's qualification to receive benefits under any assistance program.

ii. Failing, with intent to defraud, to report a change in the factors affecting the person's eligibility for benefits.

iii. Knowingly, with intent to defraud, using, attempting to use, acquiring, transferring, forgeing, altering, trafficking, counterfeiting, or possessing in any manner not authorized by law a medical identification card, food stamp, or food stamp identification card, or unique electronic authorizing codes or numbers, or electronic personal identification numbers.

iv. Misappropriating or attempting to misappropriate a food stamp authorization-to-purchase card, food stamp identification card, or Medicaid identification card or misappropriating other benefits from any program with which the person has been assigned responsibility, or knowingly failing to report any of these activities when it is clearly in violation of the law.

v. Devising, with intent to defraud or deceive, a scheme or plan a scheme or artifice to obtain benefits from any assistance program by means of false or fraudulent representations or intentionally engaging in conduct that advances the scheme or artifice.

f) Denial, Probation, Suspension, or Revocation of Licenses and Permits, Kentucky Revised Statutes Sec. 311.595

This statute prohibits physicians, osteopaths, podiatrists, and related medical practitioners from engaging in "dishonorable, unethical, or unprofessional conduct of a character likely to deceive, defraud, or harm the public or any member thereof." The Kentucky Board of Medical Licensure may deny, limit or restrict, suspend, or revoke a practitioner's license for violations.

3) *Ohio and Kentucky Providers.* Any other state law pertaining to civil or criminal penalties for false claims and statements with respect to the Medicaid program, including any law that prohibits:

i. Knowingly presenting, or causing to be presented, a false or fraudulent claim for payment or approval to the Medicaid program;

ii. Knowingly making, using, or causing to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Medicaid program;

iii. Conspiring to defraud the Medicaid program by getting a false or fraudulent claim allowed or paid;

iv. Knowingly making, using, or causing to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Medicaid program.

D. Protection for "Whistleblowers"

It is the policy of UC Health to detect and prevent any activity that may violate the False Claims Act, the Program Fraud Civil Remedies Act of 1986 or the State Medicaid Fraud Laws cited in this policy. If any employee has knowledge or information that any such activity may have taken place, the employee should notify his or her supervisor, contact the Corporate Compliance Office, or call the Helpline at 1-866-585-8030. Information may be reported to the Helpline anonymously. In addition, federal and state law and UC Health policy prohibit any retaliation or retribution against persons who report suspected violations of these laws to law enforcement officials or who file "whistleblower" lawsuits on behalf of the government. Anyone who believes that he or she has been subject to any such retribution or retaliation should also report this to the Corporate Compliance Office or the Helpline.

E. Fraud, Waste and Abuse Prevention and Detection

UC Health has developed, as part of its Corporate Compliance Program, detailed written policies for the prevention and detection of fraud, waste, and abuse in government health care programs, and for the role of employees, contractors and agents in preventing and detecting fraud, waste and abuse in such programs. UC Health policies and procedures for the prevention and detection of fraud, waste and abuse have been provided to employees, and will be made available to contractors and agents in the form of the Code of Corporate Compliance, which may be accessed on the Intranet or through the Compliance Department. If any employee has any questions or needs additional copies of the Code of Corporate Compliance, please write to the Corporate Compliance Office at: CorporateCompliance@UCHealth.com.