Policy #	12
Policy Title	Compliance with False Claims Act and Civil Monetary Penalties Laws
Effective Date	February 3, 2015
Revision Date	

Purpose:
This Policy is designed to help Team Members, agents and contractors of Mennonite Home Communities and its related entities understand the provisions of the federal and state laws regarding the submission of false claims to the federal and/or state governments for reimbursement and to inform such Team Members, agents and contractors of their rights and obligations to report violations of such federal and state laws.

Policy:
This Policy will provide information to our Team Members, agents and contractors regarding both the federal and state false claims laws as well as protections available for those who report violations of these laws. The Policy will also describe Mennonite Home Communities' policies and procedures for detecting and preventing the submission of false claims. It is important that our Team Members, agents and contractors understand the provisions of these laws and how of Mennonite Home Communities strives to comply with such laws.

The Policy covers discussions of the following:

Federal False Claims Act
Federal Civil and Criminal Penalties and Administrative Remedies
Federal "Qui Tam" or "Whistleblower" Protections
Pennsylvania False Claims Laws
Pennsylvania False Claims Laws Penalties
Pennsylvania Insurance Fraud Law
Pennsylvania Whistleblower Law
Mennonite Home Communities Procedures to Prevent and Detect Fraud

I. FEDERAL LAWS

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

The False Claims Act is a federal statute that imposes civil liability for fraud involving any federally funded government program such as Medicare or Medicaid (Medical Assistance in Pennsylvania). The federal government may bring a lawsuit under the False Claims Act against any person or entity whom it believes has knowingly presented, or caused to be presented, a false or fraudulent request for payment from the federal government, or who has made a false statement or used a false record to get a claim approved. Such false or fraudulent claims can include everything from documenting false information in a client's medical record, to using

improper codes when submitting a bill to Medicaid or Medicare. A "claim" is defined as any request or demand for money that is submitted to the United States Government (including through submissions to a contractor or grantee of the federal government). In the health care context, such a claim is typically in the form of a bill or claim form submitted to Medicare, Medicaid or another government health program for services provided or items furnished.

The False Claims Act defines "knowingly" to mean that a person must (1) have actual knowledge of the falsity of the information in the claim, (2) act in deliberate ignorance of the truth or falsity of the information in the claim, or (3) act in reckless disregard of the truth or falsity of the information in a claim. However, the False Claims Act does not require proof of a specific intent to defraud the government as health care providers are expected to know and understand the rules regarding the submission of claims. Thus, health care providers can be prosecuted under the False Claims Act for engaging in a wide variety of acts such as entering false information into a client's medical record, submitting bills to Medicare, Medicaid or any other federal government program for services never performed or items never furnished, or using improper billing codes when submitting a bill to Medicare or Medicaid.

B. Federal Civil and Criminal Penalties and Administrative Remedies

False Claims Act Civil Penalties (31 U.S.C. § 3729)

Persons or organizations who violate the False Claims Act can be subject to civil penalties ranging from $5,500 to $11,000 for each false claim submitted, **plus** three times the amount of damages sustained by the federal government.

Program Fraud and Civil Remedies Act of 1986 ("PFCRA") (31 U.S.C. §§ 3801-3812)

The PFCRA provides an administrative remedy against any person who makes a false claim or written statement to any federal agency. The PFCRA provides for civil penalties of up to $5,000 per claim for each false claim submitted to a federal agency and an assessment of no more than twice the amount of the claim. The penalties are imposed on any person (defined to include individuals, corporations and private organizations) who (1) submits a false, fictitious or fraudulent claim, (2) includes a false statement of material fact, (3) omits a material fact, or (4) makes a claim for property or services that were not provided as claimed.

Civil Monetary Penalties Law ("CMPL") (42 U.S.C. § 1320a-7a)

The CMPL provides for civil monetary penalties for a variety of prohibited acts including: (1) presenting a claim to a federal or state officer, employee or agency the person knows or should know was not provided as claimed (including upcoding claims) or is false or fraudulent, or (2) seeking payment for medical or other items and services the person knows or should know are not medically necessary. CMPL penalties may also be assessed against providers who

submit bills for services performed by individuals not licensed or excluded from federal or state health care programs, violate the federal anti-kickback statute (42 U.S.C. § 1320a-7b(b)), or violate the federal Physician Self-Referral Law (42 U.S.C. § 1395nn). The amount of the CMPL penalty depends upon the type of violation. Up to $10,000 may be imposed for false or fraudulent claims as well as an assessment of up to three times the amount improperly claimed.

Criminal Penalties (42 U.S.C. § 1320a-7b)

There are also specific federal criminal penalties for fraudulent and abusive activities, including: (1) making a false statement of a material fact in any application for benefits or payment under a federal health care program, (2) soliciting or receiving any payments for referring someone for a service or item reimbursable by a federal health care program, and (3) charging or accepting payment in excess of allowable Medicare rates. In general, such activities may be punishable as felonies by fines of up to $25,000 or imprisonment for not more than five years, or both.

Exclusion from Participation in Federal Health Care Programs (42 U.S.C. § 1320a-7)

Activities that are subject to criminal or CMPL sanctions may also be subject to mandatory or permissive exclusion from participation in federal health care programs. If a health care organization such as Mennonite Home Communities or an individual health care provider is convicted of a criminal false claims violation, the federal government may seek to exclude that organization or individual from participation in the federal health care programs such as Medicare or Medicaid.

C. Federal "Qui Tam" or "Whistleblower" Protections (31 U.S.C. § 3730)

In order to encourage individuals to come forward and report misconduct involving false claims, the False Claims Act includes a whistleblower provision that offers incentives and protections for persons who report such misconduct (such a person is referred to as a whistleblower). In general, this provision allows any person who knows about the submission of false claims to the government (such as to Medicare or Medicaid) to bring forth a lawsuit for a violation of the False Claims Act on behalf of the federal government. The lawsuit will be filed "under seal" which means that the lawsuit is kept confidential while the federal government investigates the allegation and decides how to proceed. After reviewing the allegations, the government may decide to proceed with and take over the lawsuit, or it may decline to take over the lawsuit, at which time the whistleblower can continue with the action on his or her own (referred to as a "qui tam" action). If the case is successful, the whistleblower may, depending on his or her involvement in the case, receive a percent of the amount recovered by the federal government.

The False Claims Act contains a provision to protect whistleblowers from retaliation by their employers. If a whistleblower is fired, demoted, suspended, threatened, harassed or in any way

discriminated against by his or her employer for his or her involvement in a False Claims Act action such as filing a lawsuit under the False Claims Act or assisting in the investigation of a False Claims Act action, the whistleblower is entitled to all relief required to make him or her whole. Such relief can include reinstatement with the same seniority status he or she had before the discrimination, double back pay, interest on the back pay and compensation for any special damages sustained as a result of the discriminatory treatment, including reasonable attorney fees and litigation costs.

II. STATE LAWS

A. Pennsylvania

a. Pennsylvania False Claims Laws (62 P.S. § 1407)

The Pennsylvania Public Welfare Code governs Pennsylvania's Medical Assistance (Medicaid) program and contains a provision that prohibits a number of fraudulent acts. Some of the prohibited acts include:

- Knowingly or intentionally presenting for payment or allowance any false or fraudulent claim or cost report for furnishing services or items paid for by the Medical Assistance program
- Knowingly presenting for payment or allowance any claim or cost report for medically unnecessary services or items under the Medical Assistance program
- Knowingly submitting false information for the purpose of obtaining greater reimbursement than what one is legally entitled for furnishing services or items under the Medical Assistance program
- Knowingly submitting false information for the purpose of obtaining authorization for furnishing services or items under the Medical Assistance program
- Submitting a duplicate claim for services, supplies or equipment for which the provider has already received or claimed reimbursement from any source
- Submitting a claim for services, supplies or equipment that was not provided to a person receiving Medical Assistance benefits (a "recipient")
- Submitting a claim for services, supplies or equipment which includes costs or charges not related to such services, supplies or equipment rendered to a recipient
- Submitting a claim or referring a recipient to another provider by referral, order or prescription, for services, supplies or equipment which are not documented in the record in the prescribed manner and are of little or no benefit to the client, are below the accepted medical treatment standards, or are unneeded by the client

- Submitting a claim which misrepresents the description of services, supplies or equipment dispensed or provided; the dates of services; the identity of the recipient; the identity of the attending, prescribing or referring practitioner; or the identity of the actual provider

- Submitting a claim for a service or item that was not rendered by the provider

- Making a false statement in the application for enrollment or reenrollment as a provider

b. Pennsylvania False Claims Laws Penalties

A person (including organizations) who commits any of these prohibited acts may be convicted of a third degree felony for each violation with a maximum penalty of $15,000 and seven years imprisonment. Whenever a person has been previously convicted in any state or federal court of similar conduct, subsequent violations of these prohibited acts may result in a second degree felony punishable by a maximum penalty of $25,000 and ten years imprisonment. A person convicted under this provision must also repay the amount of excess benefits or payments received plus interest and pay an amount not to exceed three times the amount of excess benefits or payments. Moreover, the provider will be excluded from the Medical Assistance program for five years.

c. Pennsylvania Insurance Fraud Law

The Pennsylvania Insurance Fraud law makes it a criminal offense to knowingly submit any false, incomplete or misleading information concerning any material fact to an insurer or self-insured. If a claim is made by computer billing or other electronic means, there is a presumption that the "knowingly" requirement has been proven. Additionally, the law provides that a provider's knowledge of a potential violation without further action may trigger another provision of the law that makes it an offense to be an owner, administrator, or team member of a health care facility and knowingly allow the use of the facility by a person who is engaged in violating the law.

d. Pennsylvania Whistleblower Law (43 P.S. § 1421 et seq.)

The Pennsylvania Whistleblower Law makes it unlawful for a public employer to discharge, threaten, discriminate or otherwise retaliate against an employee for making a good faith report (or is about to report) to the employer or appropriate authority of wrongdoing or waste or for participating in an investigation of any suspected wrongdoing. Although the Whistleblower Law defines an employee as a person who performs a service for wages or other compensation for a "public body," the Pennsylvania Superior Court has interpreted "public body" to include a skilled nursing facility that received Medicaid reimbursement. A whistleblower who believes that he or she has been retaliated against can file a lawsuit under the Pennsylvania Whistleblower Law. If the lawsuit is successful, the employee can be reinstated in his or her job

with full fringe benefits and seniority rights and receive back payments and damages, or any combination of these remedies.

Procedure:

THE MENNONITE HOME's Procedures to Prevent and Detect Fraud

As stated in Mennonite Home Communities' Code of Conduct, Mennonite Home Communities is required to comply with all applicable laws and regulations associated with its operations, including the laws discussed above. Mennonite Home Communities is committed to ethical, honest billing practices and expects every Team Member (including Team Members, officers and directors of all boards of related entities, independent contractors, subcontractors and vendors) to be vigilant in maintaining these standards at all times. Mennonite Home Communities will not tolerate any deliberately false or inaccurate billing.

Any Team Member who knowingly submits a false claim or provides information that may contribute to submitting a false claim such as falsified clinical documentation to any payer, public or private, is subject to termination. This standard applies to and will be made available to any of Mennonite Home Communities' contractors or agents who, on behalf of Mennonite Home Communities, furnish, or otherwise authorize the furnishing of Medicare or Medicaid health care items or services, perform billing or coding functions, or are involved in monitoring of health care provided by Mennonite Home Communities.

Team Members are obligated to promptly report any actual or potential wrongdoing observed. Mennonite Home Communities' Code of Conduct details the use of Mennonite Home Communities Compliance Line to report suspected misconduct. Team Members may also report any violation of one of the above referenced laws to a supervisor, a member of the management team or the Compliance Official or Officer. Team Members who lawfully report false claims are protected from retaliation and intimidation by our policy and federal and state laws.

Mennonite Home Communities promptly investigates all possible violations of law, regulation or policy, including Hotline reports and any compliance concerns brought to our attention through other means. The Compliance Official or his/her designee is responsible for directing and overseeing the investigations of any allegation of noncompliance with the above-referenced laws.

If, in consultation with legal counsel, the Compliance Official or his/her designee determines that a violation of a law or regulation above has occurred, Mennonite Home Communities will:

1) Stop submitting claims related to the alleged violation until the violating practices are corrected.

2) Remove the person who violated the law or regulation from the claims submission process and take other disciplinary action against that person as appropriate.

3) In consultation with legal counsel, notify the appropriate government agencies as required by laws or regulations and make any financial restitution or repayments in a timely manner as required by law or regulation. This includes providing any required voluntary disclosures within the time frames identified under the Patient Protection and Affordable Care Act.

4) Conduct a root-cause analysis to determine appropriate corrective measures to avoid future noncompliance with the laws and regulations discussed above.

5) Implement the appropriate corrective measures.

6) Document the investigation and corrective measures implemented.

The Compliance Official is responsible for monitoring compliance with this policy.