DEPARTMENT: Legal	**POLICY DESCRIPTION:** Ohio False Claims Statutes Policy
PAGE: 1 of 4	**REPLACES POLICY DATED:** 5/1/15
EFFECTIVE DATE: September 1, 2018	**REFERENCE NUMBER:** LL.OH.001
APPROVED BY: Ethics and Compliance Policy Committee	

SCOPE: All employees and, as defined below, contractors or agents of Company affiliates located in the State of Ohio or providing services to Medicare or Medicaid providers located in the State of Ohio, including, but not limited to, hospitals, ambulatory surgery centers, outpatient imaging centers, home health agencies, physician practices, service centers, and all Corporate Departments, Groups, Divisions 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:

Company affiliates who are Medicare or Medicaid providers in Ohio or provide services to Ohio Medicare or Medicaid providers 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, which 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. Ohio has adopted a generally applicable Medicaid anti-fraud statutes that are intended to prevent the submission of false and fraudulent claims to the Ohio Medicaid program.

FEDERAL FALSE CLAIMS LAWS

Under the federal False Claims Act, any person or entity that knowingly submits a false or fraudulent claim for payment of United States Government funds, or knowingly retains an overpayment of such funds more than 60 days, is liable for significant penalties and fines. The fines include a penalty of up to three times the Government's damages, civil penalties ranging from $10,957 to $21,916 per false claim, as adjusted by the Federal Civil Penalties Inflation Adjustment Act of 1990, plus the costs of the civil action against the entity that submitted the false claims. Generally, the federal False Claims Act applies to any federally funded program. The federal False Claims Act applies, for example, to claims submitted by healthcare providers to Medicare or Medicaid.

One of the unique aspects of the federal False Claims Act is the "qui tam" provision, commonly referred to as the "whistleblower" provision. This provision allows a private person with knowledge of a false claim to bring a civil action on behalf of the United States Government to recover the funds paid by the Government as a result of the false claim. If the suit is ultimately successful, the whistleblower who initially brought the suit may be awarded a percentage of the funds recovered. In addition, the United States Government may elect to join the qui tam suit. In this case, if the suit if successful, the

percentage of the funds awarded to the whistleblower is lower because the Government will take over the expenses of the suit.

However, regardless of whether the Government participates in the lawsuit, the court may reduce the whistleblower's share of the proceeds if the court finds that the whistleblower planned and initiated the false claim violation. Further, if the whistleblower is convicted of criminal conduct related to his or her role in the false claim, the whistleblower will be dismissed from the civil action without receiving any portion of the proceeds.

The federal False Claims Act also contains a provision that protects a whistleblower from retaliation by his or her employer. This applies to any employee who is discharged, demoted, suspended, threatened, harassed, or discriminated against in his or her employment as a result of the employee's lawful acts in furtherance of a false claims action. The whistleblower may bring an action in the appropriate federal district court and is entitled to reinstatement with the same seniority status, two times the amount of back pay, interest on the back pay, and compensation for any special damages as a result of the discrimination such as litigation costs and reasonable attorney's fees.

A similar federal law is the Program Fraud Civil Remedies Act of 1986 (the "PFCRA"). It provides administrative remedies for knowingly submitting false claims and statements. A false claim or statement includes submitting a claim or making a written statement that is for services that were not provides, or that asserts a material fact that is false, or that omits a material fact. A violation of the PFCRA results in a maximum civil penalty of $5,000 per claim plus an assessment of up to twice the amount of each false or fraudulent claim.

OHIO MEDICAID ANTI-FRAUD STATUTES

The Ohio Medicaid Fraud Statute ("OMFS") makes it unlawful for any person to: (1) knowingly make or cause to be made a false or misleading statement or representation for use in obtaining reimbursement from the Ohio Medicaid program; (2) with purpose to commit fraud or knowing that the person is facilitating fraud, charge, solicit, accept, or receive any property, money, or other consideration for goods or services in addition to the amount of reimbursement such person is entitled to under the Ohio Medicaid program; (3) knowingly alter, falsify, destroy, conceal, or remove any records that are necessary to fully disclose the nature of all goods or services for which a claim for payment was submitted to, or for which reimbursement was received from, the Ohio Medicaid program within six years after such claim or payment was made. *See* Ohio Rev. Code § 2913.40.

A person who violates the OMFS is guilty of Medicaid fraud which is at minimum a misdemeanor of the first degree, punishable by fines plus costs of the investigation and prosecution of the violation. If the value of the property, services, or funds obtained in violation of the OMFS is at least $1,000, and less than $7,500, Medicaid fraud is a felony of the fifth degree. If the value of the property, services, or funds obtained in violation of the OMFS is at least $7,500 and is less than $150,000, Medicaid fraud is a felony of the fourth degree. If the value exceeds $150,000, Medicaid fraud is a felony of the third degree. *See* Ohio Rev. Code § 2913.40.

OHIO MEDICAID PROVIDER OFFENSES

Under Ohio law, no Medicaid provider shall (a) by deception, obtain or attempt to obtain payments under the Medicaid program to which the provider is not entitled; (b) willfully receive payments to which the provider is not entitled; (c) willfully receive payments in a greater amount than that to which the provider is entitled; (d) falsify any report or document required by state or federal law, rule, or provider agreement relating to Medicaid payments. *See* Ohio Rev. Code Ann. § 5164.35.

A violator will be liable for civil penalties including payment of interest on the amount of the excess payments at the maximum interest rate allowable on the date the payment was made to the provider for the period from the date upon which payment was made, to the date upon which repayment is made to the state, as well as payment of an amount equal to three times the amount of any excess payments, of not less than $5,000 and not more than $10,000 for each deceptive claim or falsification, and all other reasonable expenses the court determines. In addition, the Medicaid director shall terminate the provider's Medicaid agreement and stop payment to the provider for Medicaid services. *See* Ohio Rev. Code Ann. § 5164.35.

Whistleblower Protections

Ohio law contains an employee protection statute that prohibits an employer from taking any disciplinary or retaliatory action against an employee because such employee, in good faith, reports to the appropriate authority a violation or suspected violation of any federal, state, or local law, ordinance, regulation, or rule and the employee reasonably believes that the violation is a felony or an improper solicitation for a contribution. An employer who violates this employee protection may be liable to the affected employee for injunctive relief or actual damages, including reinstatement, restoration of benefits and back pay. *See* Ohio Rev. Code § 4113.52.

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 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, the Company's ECO, another member of management, or with the Company's Ethics Hotline (1-800-455-1996).

Employees, including management, and any contractors or agents of Company affiliates 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 Atlas, the Company's Intranet site, or the Company

website at www.hcahealthcare.com. The following are some of the policies that are relevant to this policy and to the prevention and detection of fraud and abuse: (1) EC.025-Reporting Compliance Issues and Occurrences to the Corporate Office Policy; (2) REGS.GEN. 0.15- Correction of Errors Related to Federal and State Healthcare Programs FFS Reimbursement Policy; and (3) RB.009- Reporting of Cost Report Overpayment Policy. Note that employees, contractors, and agents of Company affiliates providing services to other, non-affiliated 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:

- Ohio Rev. Code § 2913.40
- Ohio Rev. Code § 2913.47
- Ohio Rev. Code § 4113.52
- 31 U.S.C. §§ 3801-3812
- 31 U.S.C. §§ 3729-3733
- Deficit Reduction Act of 2005, Sections 6031, 6032
- HCA Code of Conduct, “Resources for Guidance and Reporting Concerns”