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I. POLICY

It is the policy of Hunterdon Health (HHS) to be in compliance with all applicable federal and state laws, to enforce procedures designed to detect and prevent fraud, waste, and abuse regarding payments from federal and state healthcare programs to Hunterdon Healthcare System, and to protect those who report, in good faith, any concerns of actual or suspected wrongdoing.

The general purposes of this policy are as follows:
- To fulfill the requirements of Section 6032 of the Deficit Reduction Act of 2005 by providing information about federal and state false claims laws to all employees, contractors, volunteers, and agents of HHS;
- To provide protection against reprisal and retaliation to those who report, in good faith, any concern or suspicion of violation under applicable laws or regulations; and
- To establish and communicate Hunterdon's policies and procedures for preventing and detecting fraud, waste, and abuse.

II. BACKGROUND

On February 8, 2006 The Deficit Reduction Act of 2005 ("the Act") was signed into law. Section 6032 of the Act requires entities that receive more than $5 million of Medicaid funds ("Qualifying Entities") must:
- establish written policies for employees, contractors, and agents of the Qualifying Entity, that provide detailed information about state and federal false claims laws; fraud, waste, and abuse; and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in federally-funded health care programs;
- include as part of such written policies, detailed provisions regarding the Entity's policies and procedures for detecting and preventing fraud, waste, and abuse; and
- include these policies and procedures in the Entity's communications with employees, contractors, and agents, with inclusion in the organization's employee handbook (if one exists).

III. DEFINITIONS

For the purposes of this policy, the following terms shall have the meaning defined herein:

A. Abuse

The term "abuse" refers to practices that inconsistent with sound medical, fiscal, or business practices, and that result in: 1) unnecessary cost to government programs;

or 2) seeking reimbursement for goods and services that are not medically necessary or that fail to meet professionally recognized standards for healthcare.

B. Claim

"Claim" means any request for money that is submitted to the federal government or its contractors for the payment of goods and services rendered.

C. Contractor or Agent

A "contractor" or "agent" includes any contractor, subcontractor, agent, or other person which or who, on behalf of HHS, furnishes, or otherwise authorizes the furnishing of Medicaid health care items or services, performs billing or coding functions, or is involved in monitoring of health care provided by Hunterdon.

D. Fraud

The term "fraud" refers to an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in an unauthorized benefit to him or another person.

E. Knowingly

The term "knowingly" as defined in the Federal Civil False Claims Act refers to a person who has actual knowledge of the information, acts in deliberate ignorance of the truth of falsity of the information, or acts in reckless disregard of the truth or falsity of the information. No proof of specific intent to defraud is required.

F. Qui Tam or Whistleblower

The Federal Civil False Claims Act contains a provision for "actions by private persons" (i.e., ***qui tam lawsuits***) – which enable a private person to bring a civil action in the name of the government for a violation of the False Claims Act.

IV. PROCEDURES FOR DETECTING AND PREVENTING FRAUD, WASTE, AND ABUSE

A. Hunterdon's Corporate Compliance Program

Hunterdon Healthcare System has implemented a comprehensive Corporate Compliance Program that focuses on the development, implementation, and enforcement of policies and procedures designed to detect and prevent fraud, waste, and abuse regarding Hunterdon's participation in Medicare, Medicaid, and other government-funded health care programs. With regard to fraud, waste, and abuse, there are three major goals of Hunterdon's Corporate Compliance Program: 1) to maintain zero tolerance for fraud, waste, and abuse; 2) to prevent, detect, and respond to unacceptable legal risks and its financial implications; and 3) to route non-compliance issues to appropriate areas for resolution.

The Corporate Compliance Program's objectives are supported by written policies and procedures to provide protection for individuals who make good faith reports of actual or suspected violations of government regulations or Hunterdon's policies.

1. Related Policies and Procedures:
   Hunterdon's policies and procedures that relate to the detection and prevention of fraud and abuse include, but are not necessarily limited to, the following:
   a. Corporate Compliance: Code of Ethics
   b. Corporate Compliance: Hotline Reporting
   c. Corporate Compliance: Fraud & Abuse and Self-Referral Concerns
   d. Corporate Compliance: Resolution of Corporate Compliance Complaints
   e. Administrative: Conflicts of Interest
   f. Administrative: Non-Retaliation
   g. Human Resources: Conscientious Employee Protection Act & Non-Retaliation
2. Availability of Policies and Procedures:
   All Corporate Compliance policies and procedures are available to all employees via access to the HHS Intranet and by contacting the Corporate Compliance Department.

B. Responsibilities of All Parties

All Hunterdon employees, Medical Staff members, volunteers, contractors, and agents are expected to adhere to the government regulations, accreditation standards, and organizational policies that apply to their particular duties and Hunterdon's operations, as well as a high standard of ethical behavior at all times.

C. Reporting Suspected Fraud, Waste, or Abuse

All Hunterdon employees, Medical Staff members, volunteers, contractors, and agents are strongly encouraged to report all known or suspected activity that they believe may be in violation of a government regulation or a violation of any Hunterdon policy. Managers and other individuals in supervisory roles are required to report allegations presented to them and to report suspected improper activities that come to their attention in the ordinary course of performing their supervisory duties.

1. Options for Reporting:

a. Chain of Command (For Employees): Supervisor, Manager, Director
b. Vice President of Medical Affairs (For Medical Staff Members): By phone at (908) 788-6175 or by email at coates.robert@hunterdonhealthcare.org
c. Materials Management (For Vendors): By phone at (908) 788-6123.

d. Corporate Compliance Officer (All Parties): By phone at (908) 237-70598 or by email at michaels.ann@hunterdonhealthcare.org
e. Corporate Compliance Hotline (All Parties): By phone at (908) 788-2585. The Corporate Compliance Hotline is an unmanned voicemail box; Hunterdon does not attempt to identity voices or the telephone number used to place phone calls to the Hotline. All reports must contain sufficient information for the Compliance Officer to investigate the concerns raised.

2. **Investigation Process:**
Upon receipt of a credible report of suspected violations related to fraud, waste, or abuse, the Compliance Officer shall immediately begin a detailed investigation, with legal counsel contacted as appropriate. HHS will fully cooperate with federal and state agencies that conduct healthcare fraud and abuse investigations.

3. **Responsive Action:**
HHS will take appropriate disciplinary and enforcement action (i.e., corrective action plans, employee or Medical Staff disciplinary action, and contractual corrective action) against employees, Medical Staff, contractors, or agents found to have committee fraud and abuse violations. Appropriate corrective action (i.e., development or revision of policies and procedures, periodic monitoring) will be implemented to prevent similar recurrences of the improper activities.

4. **Non-Retaliation:**
HHS will take no adverse action or retribution of any kind against a staff member because he or she reports, in good faith, a suspected violation of this policy or other irregularity by any person other than the reporting member. HHS will attempt to treat such reports confidentially to the maximum extent consistent with fair and rigorous enforcement of the Code of Ethics.

V. OVERVIEW OF FEDERAL AND STATE LAWS

This policy contains a brief summary of federal and state laws related to the prevention, detection, and correction of fraud, waste, and abuse. This policy is not intended to identify all applicable laws, but rather to highlight some of the major regulatory provisions as required by the Deficit Reduction Act of 2005.

A. Federal False Claims Act ("FCA"), (31 U.S.C. §3729 et seq.)

The Act establishes liability when any person or entity improperly receives from or

avoids payment to the Federal government – tax fraud excepted. In summary, the Act prohibits:

1. knowingly presenting or causing to be presented to the Government a false claim for payment;
2. knowingly making, using, or causing to be made or used, a false record or statement to get a false claim paid or approved by the government;
3. conspiring to defraud the Government by getting a false claim allowed or paid;
4. falsely certifying the type or amount of property to be used by the Government;
5. certifying receipt of property on a document without completely knowing that the information is true;
6. knowingly buying Government property from an unauthorized officer of the Government, and;
7. knowingly making, using, or causing to be made or used a false record to avoid, or decrease an obligation to pay or transmit property to the Government.

Any individual or entity engaging in any of the seven categories of prohibited actions listed in 31 U.S.C. 3729(a), including the submission of false claims to federally-funded health care programs, shall be liable for a civil penalty which currently is not less than $5,500 and not more than $11,000 per false claim, plus three times the amount of damages sustained by the federal government. The amount of the false claims penalty is to be adjusted periodically for inflation in accordance with a federal formula.

The U.S. Attorney General may bring an action under this law. In addition, the law provides that any “whistleblower” may bring an action under this act on his own behalf and for the United States Government. These actions, which must be filed in U.S. District Court, are known as “qui tam” actions. The Government, after reviewing the complaint and supporting evidence, may decide either to take over the action, or decline to do so, in which case the whistleblower may conduct the action. If either the Government or the whistleblower is successful, the whistleblower is entitled to receive a percentage of the recovery. If prosecuted by the federal government, these qui tam actions are generally handled by the various U.S. Attorney’s Offices, or by the U.S. Justice Department.

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Whistleblower Protections:
31 U.S.C. 3730(h) provides that any employee who is subject to retaliation or discrimination by an employer in the terms and conditions of employment because the employee lawfully sought to take action or assist in taking action under this act "shall be entitled to all relief necessary to make the employee whole." This includes reinstatement with seniority restored to what it would have been without the retaliation or discrimination, double the amount of back pay, interest on back pay, and compensation for any special damages sustained as a result of the employer's actions, including litigation costs and reasonable attorney's fees.

B. Federal Program Fraud Civil Remedies Act of 1986 ("PFCRA) 38 U.S.C. §380 et seq.
This statute provides federal administrative remedies for false claims and statements, including those made to federally funded health care programs. Current civil penalties are $5,500 for each false claim or statement, and an assessment in lieu of damages sustained by the federal government of up to double damages for each false claim for which the Government makes a payment. The amount of the false claims penalty is to be adjusted periodically for inflation in accordance with a federal formula.

C. New Jersey Health Care Claims Fraud Act (N.J.S.A. 2C:21-4.2 to 2C:21-4.3 and 2C:51-5)
The New Jersey Health Care Claims Fraud Act provides the following criminal penalties for health care claims fraud, including the submission of false claims to programs funded in whole or in part with state funds:

1. A practitioner who knowingly 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;
2. A practitioner who recklessly commits health care claims fraud in the course of providing professional services is guilty of a crime of the third degree, and is subject to a fine of up to 5 times the pecuniary benefit obtained or sought to be obtained and the suspension of his license for up to 1 year;
3. A person who is not a practitioner subject to paragraph a. or b. 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 commits health care claims fraud. Such a person is

guilty of a crime of the second degree of that person knowingly commits 5 or more acts of health care claims fraud, and the aggregate monetary benefit obtained or sought to be obtained is at least $1,000. In addition to all other criminal penalties allowed by law, such a person may be subject to a fine of up to 5 times the monetary benefit obtained or sought to be obtained;

4. A person who is not a practitioner subject to paragraph a. or b. above is guilty of a crime of the fourth degree if that person recklessly commits health care claims fraud. In addition to all other criminal penalties allowed by law, such a person may be subject to a fine of up to 5 times the monetary benefit obtained or sought to be obtained.

D. New Jersey Medical Assistance and Health Services Act, Criminal Sanctions, (NJSA 30:4D-17(1)-(d))

The provisions of this statute ("MAHA") provides criminal penalties for individuals and entities engaging in fraud or other criminal violations relating to Title XIX-funded programs. They include: (a) fraudulent receipt of payments or benefits: fine of up to $10,000, imprisonment for up to 3 years, or both; (b) false claims, statements or omissions, or conversion of benefits or payments: fine of up to $10,000, imprisonment for up to 3 years, or both; (c) kickbacks, rebates and bribes: fine of up to $10,000, imprisonment for up to 3 years, or both; and (d) false statements or representations about conditions or operations of an institution or facility to qualify for payments: fine of up to $3,000, or imprisonment for up to 1 year, or both. 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.

Civil Remedies, N.J.S. 30:4D-7.h., N.J.S. 30:4D-17(e)-(i); N.J.S. 30:4D-17.1.a.:

In addition to the criminal sanctions discussed in section 3 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: recovery of overpayments, interest, up to triple damages, and a penalty (which was increased from $2,000 to $5,500 to $11,000) for each false claim as a result of the NJ False Claims Act. 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.

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In addition to recovery actions, violations can result in the 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.

E. Uniform Enforcement Act (NJS 45:1-- 21.b.and o)

This statute provides that a licensure board within the N.J. Division of Consumer Affairs "may refuse to admit a person to an examination or may refuse to issue or may suspend or revoke any certificate, registration or license issued by the board" who as engaged in "dishonesty, fraud, deception, misrepresentation, false promise or false pretense:, or has "[a]advertised fraudulently in any manner."

F. New Jersey Conscientious Employee Protection Act, "Whistleblower Act", (NJSA 34:19-1 et seq.)

This statute prohibits an employer from taking any retaliatory action against an employee because the employee does any of the following:

1. Discloses, or threatens to disclose, to a supervisor or to a public body an activity, policy or practice of the employer or another employer, with whom there is a business relationship, that the employee reasonably believes is in violation of a law, or a rule or regulation issued under the law, or, in the case of an employee who is a licensed or certified health care professional, reasonably believes constitutes improper quality of patient care;
2. Provides information to, or testifies before, any public body conducting an investigation, hearing or inquiry into any violation of law, or a rule or regulation issued under the law by the employer or another employer, with whom there is a business relationship, or, in the case of an employee who is a licensed or certified health care professional, provides information to, or testifies before, any public body conducting an investigation, hearing or inquiry into quality of patient care; or
3. Provides information involving deception of, or misrepresentation to, any shareholder, investor, client, patient, customer, employee, former employee, retiree or pensioner of the employer or any governmental entity.
4. Provides information regarding any perceived criminal or fraudulent activity, policy or practice of deception or misrepresentation which the employee reasonably believes may defraud any shareholder, investor, client, patient,

customer, employee, former employee, retiree or pensioner of the employer or any governmental entity.

5. Objects to, or refuses to participate in, any activity, policy or practice which the employee reasonably believes:
   a. Is in violation of a law, or a rule or regulation issued under the law or, if the employee is a licensed or certified health care professional, constitutes improper quality of patient care;
   b. Is fraudulent or criminal; or
   c. Is incompatible with a clear mandate of public policy concerning the public health, safety or welfare or protection of the environment. N.J.S.A. 34:19-3.

The protection against retaliation, when a disclosure is made to a public body, does not apply unless the employee has brought the activity, policy or practice to the attention of a supervisor of the employee by written notice and given the employer a reasonable opportunity to correct the activity, policy or practice. However, disclosure is not required where the employee reasonably believes that the activity, policy or practice is known to one or more supervisors of the employer or where the employee fears physical harm as a result of the disclosure, provided that the situation is emergent in nature.

G. New Jersey Consumer Fraud Act (NJS 56:8-2, 56:8-3.1, 56:8-13, 56:8-14, 56:8-15)

This Act makes unlawful the use of "any unconscionable commercial practice, deception, fraud, false pretense, false promise, misrepresentation, or the knowing concealment, suppression, or omission of any material fact", with the intent that others rely upon it, in connection with the sale, rental, or distribution of any items or services by a person, or with the subsequent performance of that person.

This law permits the N.J. Attorney General, in addition to any other penalty provided by law, to assess a penalty of not more than $10,000 for the first offense and not more than $20,000 for the second and each subsequent offense. Restitution to the victim also can be ordered.

H. New Jersey False Claims Act (NJSA 2C:32-1 et. Seq.)

The New Jersey False Claims Act (NJFCA) was enacted in January, 2008 and became effective in March 2008. It has similar provisions to the federal False Claims Act. For example, The Attorney General may bring an action against an individual or entity that makes a false claim. In addition, the NJFCA also allows individuals to bring a

private right of action in the name of the State against wrongdoers and be able to collect a penalty from those wrongdoers. Under the NJFCA, the civil penalties were increased from to $2,000 per false or fraudulent claim to the federal level which is currently $5,500 to $11,000 per false or fraudulent claim under the NJ Medical Assistance and Health Services Act.

The NJFCA provides that a person will be liable for the same penalties as under the federal False Claims Act but to the State of NJ if that person:

1. Knowingly presents or causes to be presented to an employee, officer or agent of the State, or to any contractor, grantee, or other recipient of State funds, a false or fraudulent claim for payment or approval;
2. Knowingly makes, uses, or causes to be made or used a false record or statement to get a false or fraudulent claim paid or approved by the State;
3. Conspires to defraud the State by getting a false or fraudulent claim allowed or paid by the State;
4. Has possession, custody, or control of public property or money used or to be used by the State and knowingly delivers or causes to be delivered less property than the amount for which the person receives a certificate or receipt;
5. Is authorized to make or deliver a document certifying receipt of property used or to be used by the State and, intending to defraud the entity, makes or delivers a receipt without completely knowing that the information on the receipt is true;
6. Knowingly buys, or receives as a pledge of an obligation or debt, public property from any person who lawfully may not sell or pledge the property; or
7. Knowingly makes, uses, or causes 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 State.

In addition to the above, the NJ False Claims Act has whistleblower protections within it similar to the ones under the federal False Claims Act.

I. Role of Laws for Protection of Government Health Programs & Individuals

The laws described in this policy create a comprehensive network for controlling fraud, waste, and abuse laws and New Jersey employment protection laws – thereby encouraging the reporting of fraud, waste, and abuse while creating a level of security and reassurance that employees often need when voicing their concerns.

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VI. DISSEMINATION OF INFORMATION

The Corporate Compliance Department, or its designee, is responsible for ensuring that all HHS employees (including management), contractors, and agents have access to this Policy and its attachments (if any). All such persons shall be provided an opportunity to seek clarification or more information from the Corporate Compliance Officer regarding any aspect of this Policy.

A. New Hires

Education on this Policy and Hunterdon's Corporate Compliance Program is provided to all new hires during New Hire Orientation.

B. Existing Employees

All employees will receive refresher education about Hunterdon's Corporate Compliance Program and its policy for zero-toleration of fraud, waste, and abuse on an annual basis, and as deemed necessary or appropriate when internal situations or changes to regulatory updates occur. As substantive changes to the *Employee Reference Guide* occur, changes will be communicated to employees through email, postings to boards in employee break areas, Hunterdon's online learning system, via electronic surveys, the intranet, and through other means that are deemed to be appropriate and efficient.

C. Contractors, Agents & Vendors

Communication of this Policy will be provided to contractors, agents, and vendors as they are engaged to conduct business with Hunterdon and as required by law. Contractors, vendors, and agents are required to disseminate this Policy to its employees who are acting on behalf of Hunterdon.

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References:

- **Deficit Reduction Act of 2005, S. 1932 (February 8, 2006)**
- **Federal False Claims Act, 31 U.S.C. §3729 – 3733**
- **Federal Program Fraud Civil Remedies Act of 1986 ("PFCRA) 38 U.S.C. §380 et seq.**
- **New Jersey Health Care Claims Fraud Act, N.J.S.A. 2C:21-4.2 and 4.3; N.J.S. 2C:51-5.**
- **New Jersey Medical Assistance and Health Services Act – Criminal Penalties, N.J.S.A. 30:4D-17(a) – (d)**
- **Federal Program Fraud Civil Remedies Act, 31 U.S.C. § 3801 – 3812**
- **Uniform Enforcement Act, NJS 45:1-- 21.b.and o**
- **New Jersey Conscientious Employee Protection Act, N.J.S.A. 34:19-1 et seq.**
- **New Jersey Consumer Fraud Act (NJS 56:8-2, 56:8-3.1, 56:8-13, 56:8-14, 56:8-15)**
- **New Jersey False Claims Act, NJSA 2C:32-1 et. Seq.**

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