



MERIT

■ ■ ■ *HEALTH SYSTEMS LLC*

COMPLIANCE PLAN

November 2007

333 East Main Street • Suite 300 • Louisville, KY 40202
502.753.0890 • 502.753.0894 fax • www.merithealth.com

COMMITTED TO COMMUNITIES

Table of Contents

Introduction	1
The Compliance Plan:	1
Administrative Structure	1
A. Compliance Officer	2
B. Compliance Committee	3
Communications	4
A. Communications to Employees	4
B. Communications from Employees	4
Seeking Clarification of Policy	4
How to Report Potential Wrongdoing	4
Responsibilities of Managers and Supervisors	5
Communicating Compliance Activities to Management	5
Records Retention	5
Protection of Employees	5
Departing Employees	5
C. Compliance Hotline	5
Responding to Detected Offenses	6
Education and Training	7
Auditing and Monitoring Compliance Efforts	8
Enforcement and Discipline	9
Identification of Risks; Standards and Policies	9
A. Billing and Coding Risks	9
B. Risks Arising from the Referral Statutes: The Physician Self-Referral Law (the “Stark” Law) and the Federal Anti-Kickback Statute	11
C. Emergency Medical Treatment and Labor Act (EMTALA) (Where applicable)	13
D. Substandard Care	14
E. Relationships with Federal Healthcare Beneficiaries	14
F. HIPAA Privacy and Security Rules	15
G. Other Hospital Practices	15
H. Fraud and Abuse – Section 6032 of the Deficit Reduction Act	15

Introduction

Merit Health Systems, LLC (“Merit”) strives to provide quality, cost-effective healthcare in a positive and productive work environment. In keeping with this goal, Merit is dedicated to adhering to the highest ethical standards and accordingly, recognizes the importance of compliance with all applicable state and federal laws and ethical practices. To evidence this commitment, Merit has developed and adopted this Compliance Plan, which is intended to provide a compliance roadmap for each hospital and its employees.

The Compliance Plan:

- Establishes an administrative framework for conducting an effective and diligent compliance effort
- Creates effective communication channels to deliver each hospital’s commitment to ethical business practices and receive feedback regarding adherence to these practices
- Outlines a commitment to educate personnel regarding compliance requirements and how to conduct their job activities in compliance with state and federal law and according to the policies and procedures of the Compliance Plan
- Implements monitoring and auditing functions to measure the effectiveness of the Plan and to address problems in an efficient and timely manner
- Outlines enforcement and discipline components that ensure that all personnel take their compliance responsibilities seriously
- Identifies the hospitals’ significant operating and legal risks and develops a plan to minimize those risks

The Merit Health Systems Board is responsible for the operation and oversight of the Compliance Plan; however, the day-to-day responsibility for the operation and oversight of this Compliance Plan rests with the Merit Compliance Officer. The Merit Compliance Officer is supported by a Compliance Committee.

Administrative Structure

The compliance efforts for the Merit are managed and overseen by a Compliance Officer and a Compliance Committee.

A. Compliance Officer

The Compliance Officer is responsible for directing and assuring the active functioning of the hospital's compliance efforts. As such, the Compliance Officer oversees, coordinates and monitors the day-to-day compliance activities of the hospital. General responsibilities include the following:

- Supervise prompt implementation of this Compliance Program and coordinate all compliance efforts
- Assure that all hospital employees, medical staff and contractors or agents receive a copy of the Code of Conduct and Compliance Plan and, depending on an individual's particular job responsibilities, any other written compliance policies and guidelines that may be relevant
- Establish a Compliance Committee, educate committee members regarding their compliance responsibilities and chair and oversee activities of Compliance Committee
- Develop and approve compliance education and training materials; document and implement tracking mechanisms to document attendance at or completion of required training; oversee annual employee attestations regarding commitment to compliance
- Coordinate compliance personnel issues with the hospital's human resources department to ensure that compliance is an integral part of performance assessment and that the National Practitioner Data Bank and Cumulative Sanction Report are checked with respect to all employees and agents.
- Develop communications (e-mails, newsletters, etc.) that encourage employees to report possible improper or illegal conduct
- Implement and operate retaliation-free reporting channels, including an anonymous telephone hotline
- Identify and assess areas of hospital operations that present the greatest compliance risk; prioritize resources to address those risk areas
- Work with Compliance Committee to identify risk areas warranting compliance audits
- Monitor and evaluate the Compliance Plan's effectiveness through internal and external audits; oversee internal or external resources conducting compliance audits; assess results and develop any necessary responses
- Oversee and document any compliance investigations, working with counsel as the situation warrants
- Report on a regular basis to the CEO and governing board, as well as the corporate officer responsible for compliance regarding day-to-day compliance efforts; promptly report the results of material or significant investigations

- Keep current with laws, regulations and policies applicable to compliance in order to provide the best possible advice and guidance; obtain copies of all OIG regulations, special fraud alerts and advisory opinions to ensure that the hospital's compliance policies reflect the guidance provided by the OIG
- Ensure that the hospital appropriately disciplines employees who do not adhere to the Code of Conduct and compliance policies
- Periodically (at least annually), with the Compliance Committee, assess the adequacy of the hospital's Code of Conduct and Compliance Plan and revise as necessary

B. Compliance Committee

The Compliance Committee is responsible for supporting the Compliance Officer in developing, monitoring and assessing the Compliance Plan. The committee consists of six to eight individuals representing the hospital's significant operating areas. Typically such areas include finance, billing, QA, risk management, clinical operations and human resources. The committee meets at least quarterly, or more frequently as necessary, and has the following duties and responsibilities:

- Continually analyze the hospital's risk environment, the legal requirements with which it must comply and specific risk areas
- Assess and revise existing compliance policies and procedures to assure compliance with the law, regulations and policies and procedures of government and private payer health plans
- Assist the appropriate personnel in designing and coordinating internal and external compliance reviews and monitoring activities
- Review the results of investigations and resulting corrective action plans for hospital departments, providers, or contractors
- Assess and revise policies and programs to promote compliance and encourage reporting of suspected fraud and other improprieties without fear of retaliation and to ensure proper response to reports of noncompliance
- Review the hospital's compliance training efforts
- Maintain minutes of the Committee's meetings summarizing the items addressed and actions taken at each meeting
- Maintain the confidentiality of any sensitive or proprietary information learned by a member through the Compliance Committee process

Communications

Merit's commitment to an active compliance effort is repeatedly communicated to employees through a variety of channels to encourage communication and the reporting of incidents of potential fraud and misconduct.

A. Communications to Employees

In addition to formal compliance training, employees, medical staff and outside contractors receive frequent reminders of the hospital's commitment to compliance, the various avenues for reporting concerns, and the hospital's strict policy of non-retaliation for reporting potential compliance issues. Such communications may take the following forms:

- Periodic memos from the CEO
- Compliance articles in hospital newsletters
- E-mails
- Inserts in paychecks
- Website and intranet postings

B. Communications from Employees

Processes are in place to ensure that employees, medical staff and contractors know about the various communication channels they may use to express compliance concerns. Anyone who suspects improper or illegal activity is expected to report it. In some circumstances, a failure to report such activity may be grounds for discipline.

Seeking Clarification of Policy

Hospital employees may seek clarification from a supervisor, the Compliance Officer or any member of the Compliance Committee regarding any confusion or questions about a compliance policy or procedure. Questions directed to the Compliance Committee and responses are documented and dated, and if appropriate, shared with other staff so that standards, policies and procedures can be updated and improved to reflect necessary changes or clarifications.

How to Report Potential Wrongdoing

Reports of concerns may be made orally or in writing, and should initially be directed to an employee's supervisor. If an employee is not comfortable reporting concerns to a supervisor, or if an employee is not satisfied with the response to his or her inquiries, the concerns should be directed to the hospital's Compliance Officer or to a Compliance Committee member. Issues of concern may also be reported anonymously by calling Merit's compliance hotline at (800) 826-6762.

Responsibilities of Managers and Supervisors

Managers and Supervisors will respond appropriately and honestly when possible wrongdoing is brought to their attention. It is their responsibility to relay reports of noncompliance to the Compliance Officer. In keeping with the policy allowing anonymous reports, a manager or supervisor may decline to identify the employee who originally made the report.

Communicating Compliance Activities to Management

The Compliance Officer maintains a tracking log of all concerns and complaints received, as well as the results of any investigations conducted and the outcome of the investigation. The Compliance Officer reports at least quarterly to the hospital governing board and Merit senior management regarding compliance efforts. Such reports include a report on all allegations of wrongdoing, the results of any investigations conducted and any subsequent disciplinary or remedial action taken, recent training efforts undertaken and an overview of current auditing and monitoring efforts. It may also include statistical and trending information.

Records Retention

The hospital document retention plan includes provisions to ensure that all records related to reports of wrongdoing are preserved in accordance with state and federal laws and to assure maximum protection under the attorney-client privilege and attorney work-product doctrine.

Protection of Employees

Every effort is made to maintain, within the limits of the law, the confidentiality of the identity of any individual who reports possible misconduct. There will be no retribution or discipline for anyone who reports a possible violation in good faith.

Departing Employees

Departing employees are asked to submit to an exit interview. One of the purposes of the exit interview is to determine if the employee has knowledge of wrongdoing, unethical behavior or criminal misconduct. The interview may also be used to obtain information about unsafe or unsound business practices.

C. Compliance Hotline

Merit has established a toll-free Compliance Hotline to receive questions about compliance practices and reports of suspected improper or illegal activities. The phone number for the Compliance Hotline is (800) 826 6762. Callers may remain anonymous, although callers are encouraged to provide as much information as possible so that reports can be properly investigated. No one who calls with either a question or a report of suspected misconduct will suffer any kind of retaliation or adverse action, as long as the call was made in good faith.

The people answering the calls on the Compliance Hotline are not employees of Merit or its hospitals. The person answering the telephone will ask the caller if he or she wants to remain anonymous. If so, the call will be assigned a number. The number can be used to call back and obtain information about the status of the question or concern. The person taking the call will document the call and forward it to the Merit and hospital Compliance Officers.

All questions and reports to the Compliance Hotline are kept confidential to the extent practicable. The Compliance Officer will disclose questions and reports on a “need to know” basis, except as required by law. Similarly, if a caller chooses to identify himself or herself, the Compliance Officer will keep the caller’s identity confidential and disclose the caller’s identity on to a “need to know” basis, except as required by law. In general, “need to know” means that disclosure will be made only to the extent necessary to allow for a full investigation of reports of suspected misconduct and for the implementation of any appropriate corrective actions or disciplinary sanctions.

Responding to Detected Offenses

The Compliance Officer will review all allegations of potential wrongdoing arising from hotline reports, informal communications or audits conducted by the hospital. An initial assessment is made to determine the need to involve legal counsel to advise or direct the process and to assess the need for legal privilege to protect the process. At the same time, an assessment is made to determine the appropriate resources required to conduct an investigation commensurate with the gravity of the allegation. The Compliance Officer conducts or oversees the initial investigation, along with legal counsel where it is warranted. Executive management is immediately notified if a serious allegation appears valid. Additional resources may be required to fully investigate a situation and outside resources may be utilized to conduct a full investigation. Records of an investigation contain:

- Documentation of the alleged violation
- A description of the investigative process
- Copies of interview notes and key documents
- A log of the witnesses interviewed and the documents reviewed
- The results of the investigation

If the investigation indicates that a violation has occurred, appropriate corrective action will be taken, including the following:

- Prompt restitution of any overpayments
- Notification to the appropriate government agency, where appropriate
- Review of current policies and procedures to determine if clarification is needed
- System modification

- Staff education
- Referral to criminal and /or civil law enforcement authorities
- Possible disciplinary action of involved employees, up to and including termination

Education and Training

Compliance training is provided on a regular basis to ensure that all employees are educated as to the purpose, contents and requirements of the Compliance Program. The training program consists of two components: general training and supplemental training. The Compliance Officer, working with the Compliance Committee and other hospital personnel as appropriate, develops and continuously updates such training information.

General training covers the material contained in the Code of Conduct and the Compliance Program, as well as other applicable laws, policies and procedures. It reinforces the need for strict compliance with applicable statutes, regulations, policies and procedures and advises employees about disciplinary action that may result from failure to comply. General compliance training is provided to all new employees as a part of new employee orientation. The training is updated on an annual basis thereafter. All employees receive a minimum of one hour of compliance training annually.

Supplemental training covers those items that may present a heightened risk of non-compliance, particularly those directly affected by the statutes, regulations, policies, procedures and program guidelines for Medicare, Medicaid and all other federal healthcare programs. Likely areas for potential supplemental training include the following:

- Government and private payer reimbursement principles
- General prohibitions on paying or receiving remuneration to induce referrals
- Proper confirmation of diagnoses
- Submitting a claim for physician services when rendered by a nonphysician (e.g., the “incident to” rules and the physician physical presence requirement)
- Signing a form for a physician without the physician’s authorization
- Alterations to medical records
- Prescribing medications and procedures without proper authorization
- Proper documentation of services rendered
- Duty to report misconduct
- Other areas identified by this Plan or by the Compliance Committee as representing high risk areas

Attendance and participation in training is a condition of continued employment. Upon completing Compliance Program training, each employee is required to sign a written acknowledgement confirming his or her pledge to adhere to the Compliance Program and that the individual understands that failure to comply with the Compliance Program will result in disciplinary action, up to and including, termination of employment.

Auditing and Monitoring Compliance Efforts

The hospital actively uses monitoring and auditing functions to assess the effectiveness of its Compliance Program. The types of audits and areas to be audited are determined each year by the Compliance Committee. Audits are conducted by using outside resources such as counsel, auditors or other healthcare experts or through internal personnel or through an internal audit function. Audits may include the review of a statistically valid random sample of cases, staff interviews, and trend analysis studies. The results of such audits are presented to the Compliance Committee, which assesses the results and recommends any necessary corrective measures. Such corrective measures may include additional auditing, monitoring, new policies, additional training and education. Monitoring efforts are also used to ensure compliance with laws governing:

- kickback arrangements
- the physician self-referral prohibition, including Stark II, Phase III regulations
- coding
- claims development and submission
- reimbursement
- cost reporting
- marketing practices
- fraud and abuse (Section 6032 of the Deficit Reduction Act)

While the Compliance Officer and Compliance Committee periodically assess the hospital's risk areas to determine which areas may warrant a compliance audit, certain areas by their nature present significant hospital risk potential. Accordingly, coding and billing audits are conducted at least annually and more frequently where warranted. Similarly, a review of the hospital's marketing practices and payments to physician is conducted at least annually. In certain areas identified by the Compliance Committee, an audit is performed to establish a baseline level of compliance and subsequent audits are performed to assess variations from the baseline or improvement resulting from training and oversight efforts.

At least annually, a review is performed to assess whether the Compliance Program's elements have been satisfied, e.g., whether there has been appropriate dissemination of the program's standards, training, ongoing education programs and disciplinary actions.

Enforcement and Discipline

Any employee who violates the Compliance Program or healthcare laws, regulations, or program requirements is subject to disciplinary measures, up to and including termination. Such measures will be consistent with the hospital's progressive discipline policies.

Physicians with privileges who violate the Compliance Program or healthcare laws, regulations, or program requirements are subject to discipline, up to and including the loss of privileges. Such measures will be consistent with the hospital's medical staff by-laws.

If an agent or contractor violates the Compliance Program or healthcare laws, regulations, or program requirements, the hospital will take appropriate measures such as terminating the contract, requiring repayment or requiring additional training and education.

The hospital has established a process to ensure that it does not knowingly hire, employ, or contract with any individual or entity whom the hospital knows or should have know, after reasonable inquiry, (a) has been convicted of a criminal offense related to healthcare (unless the individual or entity has been reinstated to participation in Medicare after being excluded because of the conviction), or (b) is currently listed by a federal agency as excluded, suspended or otherwise ineligible for participation in federal or federally funded programs such as Medicare and Medicaid.

Identification of Risks; Standards and Policies

The Compliance Officer and Compliance Committee assess each hospital's risk priorities at least annually. The areas identified below represent a starting point for this effort. These are areas that have been identified by the OIG as high risk areas to assist hospitals in focusing their compliance efforts. It also serves as a starting point for the hospitals' educational efforts. This is not an exclusive list of the hospitals' risk areas and others will be identified over time. Detailed standard and policies for complying with the healthcare laws and regulations implicated by these risk areas are contained in the hospital's clinical policies and procedures and are periodically reviewed to ensure that they fully address the risks presented by these areas. Further, such policies are periodically assessed to ensure consistency with the policy recommendations set forth in the OIG 1998 Model Compliance Program Guidance for Hospitals and the OIG 2005 Supplemental Compliance Program Guidance for Hospitals which can be found at <http://oig.hhs.gov>.

A. Billing and Coding Risks

Billing for items or services not actually rendered. Submitting a claim that represents that the hospital performed a service, all or part of which was not performed.

Providing medically unnecessary services. Intentionally seeking reimbursement for a service that is not warranted by a patient's current and documented medical condition.

Upcoding. Using a billing code that provides a higher payment rate than the billing code that actually reflects the service furnished to the patient.

DRG creep. Using a Diagnosis Related Group (DRG) code that provides a higher payment rate than the DRG code that accurately reflects the service furnished to the patient.

Outpatient services rendered in connection with inpatient stays. Submitting claims for non-physician outpatient services that were already included in the hospital's inpatient payment under the Prospective Payment System (PPS); in effect, submitting duplicate claims.

Duplicate billing. Submitting more than one claim for the same service or submitting a claim to more than one primary payor at the same time.

False cost reports. Submitting unallowable costs due the failure to provide proper controls over costs included in a hospital's Medicare cost report; shifting certain costs to areas that are below their reimbursement cap; shifting nonMedicare related costs to Medicare cost centers.

Unbundling. Submitting bills piecemeal or in fragmented fashion to maximize the reimbursement for various tests or procedures that are required to be billed together and therefore at a reduced cost.

Billing for discharge in lieu of transfer. Billing for a full DRG for patients that are transferred to another DRG hospital when the transferring hospital should charge Medicare only a per diem amount.

Credit balances. Failing to refund credit balances.

Other Outpatient Procedure Coding Issues. Billing on an outpatient basis for inpatient-only procedures; submitting claims for medically necessary services by failing to follow the fiscal intermediary's local medical review policies; submitting duplicate claims or otherwise not following the national Correct Coding Initiative guidelines; submitting incorrect claims for ancillary services because of outdated Charge Description Masters; Circumventing the multiple procedure discounting rules; failing to follow CMS instructions regarding the selection of proper evaluation and management codes; improperly billing for observation services.

Admission and Discharge Issues. Failing to follow the "same-day" rule; same-day discharge and readmission issues such premature discharges, medically unnecessary readmissions or incorrect discharge coding.

Supplemental Payment Considerations. Improperly reporting the costs of "pass-through" items; abuse of DRG outlier payments.

Use of Information Technology. Failing to fully understand the impact of computer systems and software that affect coding, billing or the generation or transmission of information related to the federal healthcare programs or their beneficiaries.

2008 OIG Work Plan. Hospital payments relating to: inpatient capital, new services and technologies, long-term care hospital patients, disproportionate share payments (DSH), and inpatient psychiatric faculty payments, Medicare Part B, and Medicaid DSH inpatient utilization rates as they relate to payments, as well as bad debts claimed by acute care inpatient hospitals.

B. Risks Arising from the Referral Statutes: The Physician Self-Referral Law (the “Stark” Law) and the Federal Anti-Kickback Statute.

The Stark Law. The Stark law prohibits hospitals from submitting-and Medicare from paying-any claim for a “designated health service” (DHS) if the referral of the DHS comes from a physician with whom the hospital has a prohibited financial relationship. A financial relationship can be almost any kind of direct or indirect ownership or investment relationship or direct or indirect compensation arrangement, whether in cash or in-kind, between a referring physician (or immediate family member) and a hospital.

Any financial relationship between a hospital and a physician who refers to the hospital must fit into an exception or the statute has been violated. As a rule, there are no exceptions for inadvertence or error. Accordingly, the hospital has adopted, at a minimum, specific policies to address the following aspects of physician relationships:

- frequent and thorough review of all contracts and leases with physicians to ensure that all conditions supporting the exceptions are fully satisfied
- appropriate processes for making and documenting reasonable, consistent and objective determinations of fair market value
- monitoring the total value of monetary and non-monetary compensation provided annually to each referring physician,
- tracking the provision and value of medical staff incidental benefits
- creation of a “master list” of contracts by each Merit hospital

Compliance with a Stark law exception does not immunize an arrangement under the anti-kickback statute. Rather the Stark law sets a minimum standard for arrangements between physicians and hospitals. Even if a hospital-physician relationship qualifies for a Stark law exception, it is still reviewed for compliance with the anti-kickback statute.

The Federal Anti-Kickback Statute. The anti-kickback statute is a criminal prohibition against payments (in any form, whether the payments are direct or indirect) made purposefully to induce or reward the referral or generation of federal healthcare program business. The statute extends equally to the solicitation or acceptance of remuneration for referrals or the generation of other business payable by a federal healthcare program. Although liability under the anti-kickback statute ultimately turns on a party’s intent, neither a legitimate business purpose for the arrangement nor a fair market value payment, will legitimize a payment if there is also an illegal purpose (i.e., an intent or desire to induce federal healthcare program business.).

Relationships with physicians represent the primary referral sources for the hospital and accordingly all relationships with physicians are carefully reviewed as described above. In addition the hospital may receive referrals from other healthcare professionals such as physician assistants and nurse practitioners, and from other providers and suppliers such as ambulance companies, clinics, hospices,

home health agencies, nursing facilities and other hospitals. Each of these relationships is evaluated to ensure that the anti-kickback statute is not violated.

Certain arrangements or practices that may present a significant potential for abuse are identified below and an initial framework for assessing the risk associated with those practices are described below. Further tools for analysis are available in the OIG 2005 Supplemental Compliance Program Guidance and in relevant Special Fraud Alerts available at <http://oig.hhs.gov/fraud.html>.

Joint Ventures. Any joint venture with an entity in a position to refer or generate federal healthcare program business presents the potential that remuneration from such a venture might be a disguised payment for past or future referrals to the venture. Accordingly, the hospital considers the following factors in evaluating such ventures.

- How the joint venture participants are selected and retained
- The manner in which the joint venture is structured
- The manner in which the investments are financed and profits are distributed

Whenever possible, the hospital structures joint ventures to satisfy one of the safe harbors for investments interests.

Compensation Arrangements with Physicians. Typical compensation arrangements with physicians include medical director agreements, personal or management services agreements, space or equipment leases or agreements for the provision of billing, nursing or other staff services. All remuneration flowing between hospitals and physicians is at fair market value for actual and necessary items furnished or services rendered based upon an arm's length transaction and does not take into account the value or volume of any past or future referrals or other business generated between the parties. A starting point for evaluating these arrangements is a consideration of the following factors:

- The items and services obtained from the physician are legitimate, commercially reasonable and necessary to achieve a legitimate business purpose of the hospital.
- The compensation represents fair market value in an arm's-length transaction.
- The services could not be obtained from a non-referral source at a cheaper rate or under more favorable terms.
- The determination of fair market value is based upon a reasonable methodology that is uniformly applied and properly documented in writing.
- Safeguards are in place to ensure that physicians do not use hospital space, equipment or personnel to conduct their private practice.

Whenever possible, the hospital structures physician compensation arrangements to satisfy one of the anti-kickback safe harbors.

Relationships with other Healthcare Entities. When furnishing inpatient, outpatient and related services, the hospital may direct or influence referrals for items and services reimbursable by federal healthcare programs. For example the hospital may refer patients to, or order times or services from, home health agencies, skilled nursing facilities, durable medical equipment companies, laboratories, pharmaceutical companies, and other hospitals. When the hospital is the referral source for other providers or suppliers, payments or remuneration from such other providers or suppliers is carefully reviewed to ensure compliance with the anti-kickback statute.

Physician Recruitment Arrangements. Incentives provided to recruit a physician or other healthcare professional to join the hospital's medical staff pose substantial fraud and abuse risks. All physician recruitment arrangements are reviewed in advance, with particular emphasis on the following issues:

- The size and value of the recruitment benefit
- The duration of payout of the recruitment benefit
- The physician's current practice-size and location
- The hospital and community need for the recruitments

Discounts. All discounts are properly disclosed and accurately reflected on hospital cost reports. There are no links or connections, explicit or implicit, between discounts offered or solicited for that business and the hospital's referral of business billable by the seller directly or Medicare or another federal healthcare program. Hospital personnel understand the discount safe harbor requirements.

Medical Staff Credentialing. Certain medical staff credentialing practices may implicate the anti-kickback statute such as conditioning privileges on a particular number of referrals or requiring the performance of a particular number of procedures, beyond volumes necessary to ensure clinical proficiency. Credentialing practices are reviewed periodically for compliance with these concerns.

Malpractice Insurance Subsidies. Any subsidy of a physician's malpractice insurance raises the issue of whether the payments are being used to influence referrals. All malpractice insurance subsidy arrangements are reviewed closely to ensure that there is no improper inducement to referral sources. A list of relevant factors for making that determination is provided in the OIG 2005 Supplemental Compliance Program Guidance.

C. Emergency Medical Treatment and Labor Act (EMTALA) (Where applicable)

The hospital has specific obligations under the EMTALA to evaluate and treat individuals who come to the emergency department. Hospital policies and procedure are clear on how to access the full services of the hospital in compliance with the Act and the emergency room staff understands the hospital's obligations to patients under EMTALA. Particular issues that warrant heightened education include:

- Understanding when an individual must receive a medical screening exam to determine whether the individual is suffering from an emergency medical condition

- Prohibitions on delays resulting from inquiries regarding an individual's method of payment or insurance status
- Rules governing when and how an emergency department patient may be transferred

D. Substandard Care

The OIG may exclude the hospital from participating in federal healthcare programs if the hospital provides items or services that fail to meet professionally recognized standards of healthcare. To achieve quality related goals the hospital continually measures its performance against comprehensive standards. The hospital has developed its own quality of care protocols and has implemented mechanisms for evaluating compliance with those protocols. In addition the hospital takes an active part in monitoring the quality of medical services provided at the hospital by appropriately overseeing the credentialing and peer review of the medical staff.

E. Relationships with Federal Healthcare Beneficiaries

Hospitals are prohibited from offering remuneration to a Medicare or Medicaid beneficiary that the hospital knows or should know is likely to influence the beneficiary to order or receive items or services from a particular provider. The definition of "remuneration" expressly includes the offer or transfer of terms or services for free or other than fair market value, including the waiver of all or part of a Medicare or Medicaid cost-sharing amount. Specific items of concern include the following:

Gifts. The hospital prohibits offers of gifts or gratuities to beneficiaries if the remuneration is something that the hospital knows or should know is likely to influence a beneficiary's selection of a particular provider. The restriction does not apply to items or services valued at less than \$10 per item and \$50 per patient in the aggregate on an annual basis. The hospital has educated its employees to ensure their understanding of these restrictions.

Cost Sharing Waivers. In general, the hospital is obligated to collect cost-sharing amounts owed by federal health care program beneficiaries. Waving owed amounts may constitute prohibited remuneration to beneficiaries. Certain waivers of Part A inpatient cost-sharing amounts may be protected by structuring them to fit in the safe harbor for waivers of beneficiary inpatient coinsurance and deductible amounts, e.g., waived amounts may not be claimed as bad debt, the waivers must be offered uniformly across the board, and waivers may not be made as part of any agreement with a third part payer (other than a Medicare SELECT plan.) The rules for this safe harbor are understood by employees with billing responsibility. In addition, the hospital may waive cost-sharing amounts on the basis of a beneficiary's financial need under certain circumstances. These circumstances are understood by billing personnel and the hospital uses a reasonable set of financial need guidelines that are based on objective criteria and appropriate for the hospital's location. Such determinations are well documented.

Free Transportation. While the hospital is prohibited from offering free transportation to Medicare or Medicaid beneficiaries to influence their selection of a particular provider, the hospital can offer free local transportation of low value (within the gift exception above). Certain other complimentary

transportation programs may be permissible under currently evolving rules. Prior to undertaking such transportation efforts, the hospital will have processes in place to ensure that all statutory and regulatory requirements relating to free transportation are met.

F. HIPAA Privacy and Security Rules

The hospital is subject to detailed rules that govern the use and disclosure of individuals' health information and standards for individuals' privacy rights to understand and control how their health information is used. These rules can be found at <http://www.hhs.gov/ocr/hipaa>. Penalties for failing to comply with these rules are significant. The hospital has developed privacy procedures to ensure compliance with the HIPAA Privacy and Security rules and has instituted training programs to educate all employees of their obligations with respect to these requirements.

G. Other Hospital Practices

A variety of billing issues exist with respect to making sure that the hospital is billing the government appropriately or otherwise observing the applicable guidelines for services involving the situations described below.

- Discounts to uninsured patients
- Provision of preventive care services
- Professional courtesy for a range of practices involving free or discounted services (including "insurance only" billing) furnished to physicians and their families and staff

To the extent the hospital undertakes these practices, it is done in the context of understanding fully the laws and regulations pertinent to such practices and employees are educated as to those laws and regulations.

H. Fraud and Abuse – Section 6032 of the Deficit Reduction Act

Merit and each of its hospitals strive to comply with all Federal and State rules regarding billing Medicare, Medicaid, and other government programs for services provided to our patients. We have adopted the following policies to comply with the requirements of Section 6032 of the Federal 2005 Deficit Reduction Act ("DRA 6032"). All of our employees, management personnel, contractors, vendors, business partners, and agents must abide by this policy and all other applicable Federal and State laws to prevent fraud, waste, and abuse.

The False Claims Act

The False Claims Act ("FCA") provides, in pertinent part, that:

- (a) Any person who (1) knowingly presents, or causes to be presented, to an officer or employee of the United States Government or a member of the Armed Forces of the United States 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 Government; (3) conspires to defraud the Government by getting a false or fraudulent claim paid or approved by the Government; . . . 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 Government,

is liable to the United States Government for a civil penalty of not less than \$5,000 and not more than \$10,000, plus 3 times the amount of damages which the Government sustains because of the act of that person

(b) For purposes of this section, the terms “knowing” and “knowingly” mean that a person, with respect to information (1) has actual knowledge of the information; (2) acts in deliberate ignorance of the truth or falsity of the information; or (3) acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required.

31 U.S.C. § 3729. While the False Claims Act imposes liability only when the claimant acts “knowingly,” it does not require that the person submitting the claim have actual knowledge that the claim is false. A person who acts in reckless disregard or in deliberate ignorance of the truth or falsity of the information, also can be found liable under the Act. 31 U.S.C. 3729(b).

In sum, the False Claims Act imposes liability on any person who submits a claim to the federal government that he or she knows (or should know) is false. An example may be a physician who submits a bill to Medicare for medical services she knows she has not provided. The False Claims Act also imposes liability on an individual who may knowingly submit a false record in order to obtain payment from the government. An example of this may include a government contractor who submits records that he knows (or should know) is false and that indicate compliance with certain contractual or regulatory requirements. The third area of liability includes those instances in which someone may obtain money from the federal government to which he may not be entitled, and then uses false statements or records in order to retain the money. An example of this so-called “reverse false claim” may include a hospital who obtains interim payments from Medicare throughout the year, and then knowingly files a false cost report at the end of the year in order to avoid making a refund to the Medicare program.

In addition to its substantive provisions, the FCA provides that private parties may bring an action on behalf of the United States. 31 U.S.C. 3730 (b). These private parties, known as “qui tam relators,” may share in a percentage of the proceeds from an FCA action or settlement.

Section 3730(d)(1) of the FCA provides, with some exceptions, that a qui tam relator, when the Government has intervened in the lawsuit, shall receive at least 15 percent but not more than 25 percent of the proceeds of the FCA action depending upon the extent to which the relator substantially contributed to the prosecution of the action. When the Government does not intervene, section 3730(d)(2) provides that the relator shall receive an amount that the court decides is reasonable and shall be not less than 25 percent and not more than 30 percent.

The FCA provides protection to qui tam relators who are discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of their employment as a result of their furtherance of an action under the FCA. 31 U.S.C. 3730(h). Remedies include reinstatement with comparable seniority as the qui tam relator would have had but for the discrimination, two times the amount of any back pay, interest on any back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees.

Administrative Remedies

Sections 3729 to 3733 of Title 31 of the United States Code provide for the following remedies for false claims:

Any person who makes a claim for reimbursement (a) that the person knows or has reason to know is false, (b) that includes any written statement which asserts a material fact which is false, and (c) that is a statement in which the person making, presenting, or submitting the statement has a duty to include the material fact, will be subject to a penalty of up to \$5,000 for each claim, and any other remedy that may be prescribed by law.

Any person who makes, presents or submits a written statement that (a) the person knows or has reason to know asserts a material fact that is false or is false because of an omission, and (b) contains an affirmation of the truthfulness of the statement, will be subject to a penalty up to \$5,000 penalty for each such statement, and any other remedy that may be prescribed by law.

State Laws

ILLINOIS.

Under **740 ILCS 175/3 of the Illinois Whistleblower Reward and Protection Act**, any person who:

- knowingly presents, or causes to be presented, to an officer or employee of the State or a member of the Guard a false or fraudulent claim for payment or approval;
- 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;
- conspires to defraud the State by getting a false or fraudulent claim allowed or paid;
- has possession, custody, or control of property or money used, or to be used, by the State and, intending to defraud the State or willfully to conceal the property, delivers, or causes to be delivered, less property than the amount for which the person receives a certificate or receipt;
- authorized to make or deliver a document certifying receipt of property used, or to be used, by the State and, intending to defraud the State, makes or delivers the receipt without completely knowing that the information on the receipt is true;

- knowingly buys, or receives as a pledge of an obligation or debt, public property from an officer or employee of the State, or a member of the Guard, who lawfully may not sell or pledge the property; or
- 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,

may be liable to the State for a civil penalty between \$5,000 and \$10,000, three times the amount of damages which the State sustains because of the act of that person, and the costs of a civil action brought to recover a penalty or damages.

Under **740 ILCS 175/4**, the Attorney General or a private citizen may bring a civil action in the name of the state of Illinois against a person for a false claim. If the State proceeds with the action, it will have the primary responsibility for prosecuting the action, and will not be bound by an act of the person bringing the action. The private citizen will have the right to continue as a party to the action, subject to certain limitations. If the State elects not to proceed with the action, the person who initiated the action will have the right to conduct the action. The State may elect to pursue its claim through any alternate remedy available to the State, including any administrative proceeding, to determine a civil money penalty. In this instance, the person initiating the action will have the same rights as the person would have in a civil action. If the State proceeds with an action brought by a person, the person may be entitled to receive a portion of the proceeds from the claim. If the State does not proceed with an action under this Section, the person bringing the action or settling the claim will receive an amount which the court decides is reasonable.

Under **740 ILCS 175/4(g)**, any employee who is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment by his or her employer because of an investigation for, initiation of, testimony for, or assistance in an action filed or to be filed under this Statute, will be entitled to relief which may include: reinstatement of employment, two times the amount of back pay, interest on the back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees. An employee may bring an action in the appropriate circuit court to obtain this relief.

2. As used in this act: "Health care claims fraud" means making, or causing to be made, a false, fictitious, fraudulent, or misleading statement of material fact in, or omitting a material fact from, or causing a material fact to be omitted from, any record, bill, claim or other document, in writing, electronically or in any other form, that a person attempts to submit, submits, causes to be submitted, or attempts to cause to be submitted for payment or reimbursement for health care services. "Practitioner" means a person licensed in this State to practice medicine and surgery, chiropractic, podiatric medicine, dentistry, optometry, psychology, pharmacy, nursing, physical therapy, or law; any other person licensed, registered or certified by any State agency to practice a profession or occupation in the State of New Jersey or any person similarly licensed, registered, or certified in another jurisdiction.

NEW JERSEY**Under the New Jersey Medical Assistance and Health Services Act – Criminal Penalties (NJS 30:4D-17):**

(a) Any person who willfully obtains benefits under this act to which he is not entitled or in a greater amount than that to which he is entitled, and any provider who willfully receives medical assistance payments to which he is not entitled or in a greater amount than that to which he is entitled is guilty of a high misdemeanor and may be imprisoned for up to three years, be fined \$10,000.00, or both.

(b) Any provider, or any person, firm, partnership, corporation or entity, who: (1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any cost study, claim form, or any document necessary to apply for or receive any benefit or payment under this act; **or** (2) at any time knowingly and willfully makes or causes to be made any false statement, written or oral, of a material fact for use in determining rights to such benefit or payment under this act; **or** (3) conceals or fails to disclose the occurrence of an event which (i) affects his initial or continued right to any such benefit or payment, or (ii) affects the initial or continued right to any such benefit or payment of any provider or any person, firm, partnership, corporation or other entity in whose behalf he has applied for or is receiving such benefit or payment, with an intent to fraudulently secure benefits or payments not authorized under this act or in greater amount than that which is authorized under this act; **or** (4) knowingly and willfully converts benefits or payments or any part thereof received for the use and benefit of any provider or any person, firm, partnership, corporation or other entity to a use other than the use and benefit of such provider or such person, firm, partnership, corporation or entity; is guilty of a is guilty of a high misdemeanor and may be imprisoned for up to three years, be fined \$10,000.00, or both.

(c) Any provider, or any person, firm, partnership, corporation or entity who solicits, offers, or receives any kickback, rebate or bribe in connection with: (1) the furnishing of items or services for which payment is or may be made in whole or in part under this act; **or** (2) the furnishing of items or services whose cost is or may be reported in whole or in part in order to obtain benefits or payments under this act; **or** (3) the receipt of any benefit or payment under this act, is guilty of a high misdemeanor and may be imprisoned for up to three years, be fined \$10,000.00, or both. This subsection does not apply to (A) a discount or other reduction in price under this act if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made under this act; and (B) any amount paid by an employer to an employee who has a bona fide employment relationship with such employer for employment in the provision of covered items or services.

(d) Whoever knowingly and willfully makes or causes to be made or induces or seeks to induce the making of any false statement or representation of a material fact with respect to the conditions or operations of any institution or facility in order that such institution or facility may qualify either upon initial certification or recertification as a hospital, skilled nursing facility, intermediate care facility, or health agency, thereby entitling them to receive payments under this act, is guilty of a high misdemeanor and may be imprisoned for up to one year, be fined \$3,000.00, or both.

Under the **New Jersey Medical Assistance and Health Services Act (30:4D-7h)**:

2.(a) A pediatric rehabilitation hospital licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) with 30 or fewer beds shall be reimbursed 100% of its Medicaid allowable reimbursable costs as defined by Medicare Principles of Reimbursement, subject to the "Tax Equity and Fiscal Responsibility Act of 1982" (TEFRA), Pub.L.97-248 as amended, and adjusted for occupancy, if applicable.

(b) A pediatric rehabilitation hospital licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) with more than 30 beds shall be reimbursed a prospective per diem rate by the State Medicaid program for Medicaid fee-for-service recipients. The initial prospective per diem rate shall be based on the total allowable cost for Medicaid patients divided by the total Medicaid days from the calendar year 1999 Medicare/Medicaid cost report, and shall be considered the base year rate. If the hospital has been in operation less than two full years prior to fiscal year 1999, the prospective per diem rate will be set using its first finalized audited fiscal year 2000 Medicaid/Medicare cost report. The base year rate shall be updated each year by the economic factor specified in N.J.A.C.10:52-5.13. The Commissioner of Human Services shall adopt regulations to permit a pediatric rehabilitation hospital to seek rate relief or to seek a new base year rate in the event the hospital has experienced an increase in its operating costs which would impact the existing per diem rate, net of capital costs, greater than 5%. The hospital shall furnish evidence of that increase in costs to the Division of Medical Assistance and Health Services in the Department of Human Services and request an adjustment to its prospective inpatient reimbursement rate.

(c) A pediatric rehabilitation hospital licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall be: (1) reimbursed its outpatient costs based on applicable cost-based Medicare Principles of Reimbursement through the Medicare/Medicaid cost report, and shall not receive final reimbursement based on an outpatient prospective reimbursement methodology. If necessary, the Department of Human Services shall adopt regulations to specify an interim claims processing and payment methodology; (2) entitled to a per diem adjustment to account for increases in its capital expenditures. Adjusted per diem payments shall begin upon project completion and facility operation. The adjustment shall be calculated based on the Medicaid share of the inpatient costs for any capital expenditures made on or after December 31, 2003. Utilizing data from the Medicare/Medicaid Cost Report, the Medicaid share shall be determined by dividing the combined total of Medicaid fee-for-service days and Medicaid managed care days by the total number of inpatient days; and the inpatient costs for capital expenditures shall be determined by dividing the hospital's inpatient costs by its total costs and multiplying that number by its total additional capital costs; and (3) entitled to receive a per diem adjustment for its graduate medical education program, with the adjustment to be based on the Medicaid share of the costs incurred by the graduate medical education program. The Medicaid share shall be determined by dividing the Medicaid inpatient days by the total number of inpatient days and multiplying that number by the total amount of graduate medical education costs as reported on the Medicare/Medicaid cost report.

Under the **New Jersey Medical Assistance and Health Services Act (30:4D-17)**:

(e) Any person, firm, corporation, partnership, or other legal entity who violates the provisions of any of the foregoing subsections of this section shall, in addition to any other penalties provided by law, be liable to civil penalties of (1) payment of interest on the amount of the excess benefits or

payments at the maximum legal rate in effect on the date the payment was made to said person, firm, corporation, partnership or other legal entity for the period from the date upon which payment was made to the date upon which repayment is made to the State, (2) payment of an amount not to exceed three-fold the amount of such excess benefits or payments, and (3) payment in the sum of \$2,000.00 for each excessive claim for assistance, benefits or payments.

(f) Any person, firm, corporation, partnership or other legal entity, other than an individual recipient of medical services reimbursable by the Division of Medical Assistance and Health Services, who, without intent to violate this act, obtains medical assistance or other benefits or payments under this act in excess of the amount to which he is entitled, shall be liable to a civil penalty of payment of interest on the amount of the excess benefits or payments at the maximum legal rate in effect on the date the benefit or payment was made to said person, firm, corporation, partnership, or other legal entity for the period from September 15, 1976 or the date upon which payment was made, whichever is later, to the date upon which repayment is made to the State, provided, however, that no such person, firm, corporation, partnership or other legal entity shall be liable to such civil penalty when excess medical assistance or other benefits or payments under this act are obtained by such person, firm, corporation, partnership or other legal entity as a result of error made by the Division of Medical Assistance and Health Services, as determined by said division; provided, further, that if preliminary notification of an overpayment is not given to a provider by the division within 180 days after completion of the field audit as defined by regulation, no interest shall accrue during the period beginning 180 days after completion of the field audit and ending on the date preliminary notification is given to the provider.

(g) All interest and civil penalties provided for in this act and all medical assistance and other benefits to which a person, firm, corporation, partnership, or other legal entity was not entitled shall be recovered in an administrative procedure held pursuant to the "Administrative Procedure Act," P.L.1968, c. 410 (C. 52:14B-1, et seq.), except that recovery actions against minors or incompetents shall be initiated in a court of competent jurisdiction.

(h) Upon the failure of any person, firm, corporation, partnership or other legal entity to comply within 10 days after service of any order of the director or his designee directing payment of any amount found to be due pursuant to subsection (g) of this section, or at any time prior to any final agency adjudication not involving a recipient or former recipient of benefits under this act, the director may issue a certificate to the clerk of the superior court that such person, firm, corporation, partnership or other legal entity is indebted to the State for the payment of such amount. A copy of such certificate shall be served upon the person, firm, corporation, partnership or other legal entity against whom the order was entered. Thereupon the clerk shall immediately enter upon his record of docketed judgments the name of the person, firm, corporation, partnership or other legal entity so indebted, and of the State, a designation of the statute under which such amount is found to be due, the amount due, and the date of the certification. Such entry shall have the same force and effect as the entry of a docketed judgment in the Superior Court. Such entry, however, shall be without prejudice to the right of appeal to the Appellate Division of the Superior Court from the final order of the director or his designee.

(i) In order to satisfy any recovery claim asserted against a provider under this section, whether or not that claim has been the subject of final agency adjudication, the division or its fiscal agents is authorized to withhold funds otherwise payable under this act to the provider.

Under the **New Jersey Medical Assistance and Health Services Act (30:4D-17)**: (a) The director may suspend, debar or disqualify for good cause any provider presently participating or who has applied for participation in the program, or may suspend, debar or disqualify for good cause any person, company, firm, association, corporation or other entity who is participating directly or indirectly in the Medicaid program, or who is an agent, servant, employee or independent contractor of a provider in the Medicaid program.

Under **The Health Care Claims Fraud Act (NJS 2C:21-4.2 & 4.3)**

3.(a) A practitioner is guilty of a crime of the second degree if that person knowingly commits health care claims fraud in the course of providing professional services. In addition to all other criminal penalties allowed by law, a person convicted under this subsection may be subject to a fine of up to five times the pecuniary benefit obtained or sought to be obtained.

(b) A practitioner is guilty of a crime of the third degree if that person recklessly commits health care claims fraud in the course of providing professional services. In addition to all other criminal penalties allowed by law, a person convicted under this subsection may be subject to a fine of up to five times the pecuniary benefit obtained or sought to be obtained.

(c) A person, who is not a practitioner subject to the provisions of subsection a. or b. of this section, is guilty of a crime of the third degree if that person knowingly commits health care claims fraud. A person, who is not a practitioner subject to the provisions of subsection a. or b. of this section, is guilty of a crime of the second degree if that person knowingly commits five or more acts of health care claims fraud and the aggregate pecuniary benefit obtained or sought to be obtained is at least \$1,000. In addition to all other criminal penalties allowed by law, a person convicted under this subsection may be subject to a fine of up to five times the pecuniary benefit obtained or sought to be obtained.

(d) A person, who is not a practitioner subject to the provisions of subsection a. or b. of this section, 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, a person convicted under this subsection may be subject to a fine of up to five times the pecuniary benefit obtained or sought to be obtained.

(e) Each act of health care claims fraud shall constitute an additional, separate and distinct offense, except that five or more separate acts may be aggregated for the purpose of establishing liability pursuant to subsection c. of this section. Multiple acts of health care claims fraud which are contained in a single record, bill, claim, application, payment, affidavit, certification or other document shall each constitute an additional, separate and distinct offense for purposes of this section.

(f) (1) The falsity, fictitiousness, fraudulence or misleading nature of a statement may be inferred by the trier of fact in the case of a practitioner who attempts to submit, submits, causes

to be submitted, or attempts to cause to be submitted, any record, bill, claim or other document for treatment or procedure without the practitioner, or an associate of the practitioner, having performed an assessment of the physical or mental condition of the patient or client necessary to determine the appropriate course of treatment. (2) The falsity, fictitiousness, fraudulence or misleading nature of a statement may be inferred by the trier of fact in the case of a person who attempts to submit, submits, causes to be submitted, or attempts to cause to be submitted any record, bill, claim or other document for more treatments or procedures than can be performed during the time in which the treatments or procedures were represented to have been performed. (3) Proof that a practitioner has signed or initialed a record, bill, claim or other document gives rise to an inference that the practitioner has read and reviewed that record, bill, claim or other document.

(g) In order to promote the uniform enforcement of this act, the Attorney General shall develop health care claims fraud prosecution guidelines and disseminate them to the county prosecutors within 120 days of the effective date of this act.

(h) For the purposes of this section, a person acts recklessly with respect to a material element of an offense when he consciously disregards a substantial and unjustifiable risk that the material element exists or will result from his conduct. The risk must be of such a nature and degree that, considering the nature and purpose of the actor's conduct and the circumstances known to him, its disregard involves a gross deviation from the standard of conduct that a reasonable person would observe in the actor's situation.

(i) (1) Nothing in this act shall preclude an indictment and conviction for any other offense defined by the laws of this State. (2) Nothing in this act shall preclude an assignment judge from dismissing a prosecution of health care claims fraud if the assignment judge determines, pursuant to N.J.S.2C:2-11, the conduct charged to be a de minimis infraction.

Under **The Health Care Claims Fraud Act (2C:21-4.4)**

71. With respect to sections 72 through 74 of P.L.2003, c.89 (C.2C:21-4.5 through C.2C:21-4.7), the Legislature finds and declares:

(a) Insurance fraud is inimical to public safety, welfare and order within the State of New Jersey. Insurance fraud is pervasive and expensive, costing consumers and businesses millions of dollars in direct and indirect losses each year. Insurance fraud increases insurance premiums, to the detriment of individual policyholders, small businesses, large corporations and governmental entities. All New Jerseyans ultimately bear the societal burdens and costs caused by those who commit insurance fraud.

(b) The problem of insurance fraud must be confronted aggressively by facilitating the detection, investigation and prosecution of such misconduct, as well as by reducing its occurrence and achieving deterrence through the implementation of measures that more precisely target specific conduct constituting insurance fraud.

(c) To enable more efficient prosecution of criminally culpable persons who knowingly commit or assist or conspire with others in committing fraud against insurance companies, it is necessary to establish a crime of "insurance fraud" to directly and comprehensively criminalize this type of

harmful conduct, with substantial criminal penalties to punish wrongdoers and to appropriately deter others from such illicit activity.

(d) In addition to criminal penalties, in order to maintain the public trust and ensure the integrity of professional licensees and certificate-holders who by virtue of their professions are involved in insurance transactions, it is appropriate to provide civil remedial provisions governing license or certificate forfeiture and suspension tailored to this new crime of insurance fraud and other criminal insurance-related activities.

(e) To enhance the State's ability to detect insurance fraud, which will lead to more productive investigations and, ultimately, more successful criminal prosecutions, it is appropriate to provide members of the public with significant incentives to come forward when they may have reasonable suspicions or knowledge of a person or persons committing insurance fraud. The establishment of an Insurance Fraud Detection Reward Program will enable the Insurance Fraud Prosecutor to obtain information which may lead to the arrest, prosecution and conviction of persons or entities who have committed insurance-related fraud.

Under **The Health Care Claims Fraud Act (2C:51-5)**:

4.(a)(1) A practitioner convicted of health care claims fraud pursuant to subsection a. of section 3 of P.L.1997, c.353 (C.2C:21-4.3) or a substantially similar crime under the laws of another state or the United States shall forfeit his license and be forever barred from the practice of the profession unless the court finds that such license forfeiture would be a serious injustice which overrides the need to deter such conduct by others and in such case the court shall determine an appropriate period of license suspension which shall be for a period of not less than one year. If the court does not permanently forfeit such license pursuant to this paragraph, the sentence shall not become final for 10 days in order to permit the appeal of such sentence by the prosecution.

(2) Upon a first conviction of health care claims fraud pursuant to subsection b. of section 3 of P.L.1997, c.353 (C.2C:21-4.3) or a substantially similar crime under the laws of another state or the United States, a practitioner shall have his license suspended and be barred from the practice of the profession for a period of at least one year.

(3) Upon a second conviction of health care claims fraud pursuant to subsection b. of section 3 of P.L.1997, c.353 (C.2C:21-4.3) or a substantially similar crime under the laws of another state or the United States, a practitioner shall forfeit his license and be forever barred from the practice of the profession.

(4) A person convicted of second degree insurance fraud pursuant to section 73 of P.L.2003, c.89 (C.2C:21-4.6) or a substantially similar crime under the laws of another state or the United States who holds a license or certificate of authority or qualification to engage in the practice of a profession, occupation, trade, or vocation or business, including but not limited to a practitioner as defined in section 2 of P.L.1997, c.353 (C.2C:21-4.2), shall forfeit that license or certificate and be forever barred from the practice of that profession, occupation, trade, vocation or business if the act or acts of insurance fraud were related to or performed while engaged in the practice of that profession, occupation, trade, vocation or business, unless the court finds that such license or

certificate forfeiture would be a serious injustice which overrides the need to deter such conduct by others and in that case the court shall determine an appropriate period of license or certificate suspension which shall be for a period of not less than one year. If the court does not permanently forfeit such license or certificate pursuant to this paragraph, the sentence shall not become final for 10 days in order to permit the appeal of that sentence by the prosecution.

(5) A person convicted of third degree insurance fraud pursuant to section 73 of P.L.2003, c.89 (C.2C:21-4.6) or a substantially similar crime under the laws of another state or the United States who holds a license or certificate of authority or qualification to engage in the practice of a profession, occupation, trade, vocation or business, including but not limited to a practitioner as defined in section 2 of P.L.1997, c.353 (C.2C:21-4.2), shall have his license or certificate suspended and be barred from the practice of that profession, occupation, trade, vocation or business for a period of at least one year if the act or acts of insurance fraud were related to or performed while engaged in the practice of that profession, occupation, trade, vocation or business.

(6) Upon a second conviction of third degree insurance fraud pursuant to section 73 of P.L.2003, c.89 (C.2C:21-4.6) or a substantially similar crime under the laws of another state or the United States which meets the criteria of paragraph (2) of this subsection, a person shall forfeit his license or certificate and be forever barred from the practice of that profession, occupation, trade, vocation or business.

(7) Upon application of the county prosecutor or the Attorney General, a person convicted of any crime of the second degree or above enumerated in chapter 20 or 21 of Title 2C of the New Jersey Statutes or a substantially similar crime under the laws of another state or the United States who holds a license or certificate or authority or qualification to engage in the practice of a profession, occupation, trade, vocation or business, including a practitioner as defined in section 2 of P.L.1997, c.353 (C.2C:21-4.2), shall forfeit such license or certificate and be forever barred from the practice of that profession, occupation, trade, vocation or business if the act or acts underlying the conviction involved or were related to an insurance transaction as defined in section 72 of P.L.2003, c.89 (C.2C:21-4.5) and touched upon or were performed while engaged in the practice of that profession, occupation, trade, vocation or business, unless the court finds that the license or certificate forfeiture would be a serious injustice which overrides the need to deter such conduct by others and in that case the court shall determine an appropriate period of license or certificate suspension which shall be for a period of not less than one year. If the court does not permanently forfeit that license or certificate pursuant to this paragraph, the sentence shall not become final for 10 days in order to permit the appeal of that sentence by the prosecution.

(8) Upon application of the county prosecutor or the Attorney General, a person convicted of any crime of the third degree enumerated in chapter 20 or 21 of Title 2C of the New Jersey Statutes or a substantially similar crime under the laws of another state or the United States who holds a license or certificate of authority or qualification to engage in the practice of a profession, occupation, trade, vocation or business, including but not limited to a practitioner as defined in section 2 of P.L.1997, c.353 (C.2C:21-4.2), shall have his license or certificate suspended and be barred from the practice of that profession, occupation, trade, vocation or business for a period of at least one year if the act or acts underlying the conviction involved or were related to an insurance

transaction as defined in section 72 of P.L.2003, c.89 (C.2C:21-4.5) and touched upon or were performed while engaged in the practice of that profession, occupation, trade, vocation or business.

(b) A court of this State shall enter an order of license or certificate forfeiture or suspension pursuant to subsection a. of this section: (1) Immediately upon a finding of guilt by the trier of fact or a plea of guilty entered in any court of this State; or (2) Upon application of the county prosecutor or the Attorney General, when the license or certificate forfeiture or suspension is made pursuant to paragraph (4) of subsection a. of this section or is based upon a conviction of an offense under the laws of another state or of the United States. An order of license or certificate forfeiture or suspension pursuant to this paragraph shall be effective as of the date the person is found guilty by the trier of fact or pleads guilty to the offense. This application may also be made in the alternative by the Attorney General to the appropriate licensing agency. The court shall provide notice of the forfeiture or suspension to the appropriate licensing agency within 10 days of the date an order of forfeiture or suspension is entered.

(c) No court shall grant a stay of an order of license or certificate forfeiture or suspension pending appeal of a conviction or forfeiture or suspension order unless the court is clearly convinced that there is a substantial likelihood of success on the merits. If the conviction is reversed or the order of license or certificate forfeiture or suspension is overturned, the court shall provide notice of reinstatement to the appropriate licensing agency within 10 days of the date of the order of reinstatement. The license or certificate shall be restored, in accordance with applicable procedures, unless the appropriate licensing agency determines to suspend or revoke the license or certificate.

(d) In any case in which the issue of license or certificate forfeiture or suspension is not raised in a court of this State at the time of a finding of guilt, entry of a guilty plea or sentencing, a license or certificate forfeiture or suspension required by this section may be ordered by a court or by the appropriate licensing agency of this State upon application of the county prosecutor or the Attorney General or upon application of the appropriate licensing agency having authority to revoke or suspend the professional's license or certificate. The fact that a court has declined to order license or certificate forfeiture or suspension shall not preclude the appropriate licensing agency having authority to revoke or suspend the professional's license or certificate from seeking to do so on the ground that the conduct giving rise to the conviction demonstrates that the person is unfit to hold the license or certificate or is otherwise liable for an offense as specified in section 8 of P.L.1978, c.73 (C.45:1-21).

(e) If the Supreme Court of the State of New Jersey issues Rules of Court pursuant to this act, the Supreme Court may revoke the license to practice law of any attorney who has been convicted, under the laws of this State, of health care claims fraud pursuant to section 3 of P.L.1997, c.353 (C.2C:21-4.3), or an offense which, if committed in this State, would constitute health care claims fraud, insurance fraud pursuant to section 73 of P.L.2003, c.89 (C.2C:21-4.6), or an offense which, if committed in this State, would constitute insurance fraud.

(f) Nothing in this section shall be construed to prevent or limit the appropriate licensing agency or any other party from taking any other action permitted by law against the practitioner.

Under **The Conscientious Employee Protection Act (NJS 34-19-1 et seq)**:

34:19-3 Retaliatory action prohibited.

3. An employer shall not take any retaliatory action against an employee because the employee does any of the following:

(a) 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: (1) is in violation of a law, or a rule or regulation promulgated pursuant to law, including any violation 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, or, in the case of an employee who is a licensed or certified health care professional, reasonably believes constitutes improper quality of patient care; or (2) is fraudulent or criminal, including any 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;

(b) 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 promulgated pursuant to law by the employer, or another employer, with whom there is a business relationship, including any violation 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, 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 the quality of patient care; or

(c) Objects to, or refuses to participate in any activity, policy or practice which the employee reasonably believes: (1) is in violation of a law, or a rule or regulation promulgated pursuant to law, including any violation 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, or, if the employee is a licensed or certified health care professional, constitutes improper quality of patient care; (2) is fraudulent or criminal, including any 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; or (3) is incompatible with a clear mandate of public policy concerning the public health, safety or welfare or protection of the environment.

34:19-4. Written notice required. The protection against retaliatory action provided by this act pertaining to disclosure to a public body shall not apply to an employee who makes a disclosure to a public body unless the employee has brought the activity, policy or practice in violation of a law, or a rule or regulation promulgated pursuant to law to the attention of a supervisor of the employee by written notice and has afforded the employer a reasonable opportunity to correct the activity, policy or practice. Disclosure shall not be required where the employee is reasonably certain that the activity, policy or practice is known to one or more supervisors of the employer or where the

employee reasonably fears physical harm as a result of the disclosure provided, however, that the situation is emergency in nature.

34:19-5 Civil action, jury trial; remedies. Upon a violation of any of the provisions of this act, an aggrieved employee or former employee may, within one year, institute a civil action in a court of competent jurisdiction. Upon the application of any party, a jury trial shall be directed to try the validity of any claim under this act specified in the suit. All remedies available in common law tort actions shall be available to prevailing plaintiffs. These remedies are in addition to any legal or equitable relief provided by this act or any other statute. The court shall also order, where appropriate and to the fullest extent possible: a. an injunction to restrain any violation of this act which is continuing at the time that the court issues its order; b. the reinstatement of the employee to the same position held before the retaliatory action, or to an equivalent position; the reinstatement of full fringe benefits and seniority rights; the compensation for all lost wages, benefits and other remuneration; and e. the payment by the employer of reasonable costs, and attorney's fees.

In addition, the court or jury may order: the assessment of a civil fine of not more than \$10,000 for the first violation of the act and not more than \$20,000 for each subsequent violation, which shall be paid to the State Treasurer for deposit in the General Fund; punitive damages; or both a civil fine and punitive damages. In determining the amount of punitive damages, the court or jury shall consider not only the amount of compensatory damages awarded to the employee, but also the amount of all damages caused to shareholders, investors, clients, patients, customers, employees, former employees, retirees or pensioners of the employer, or to the public or any governmental entity, by the activities, policies or practices of the employer which the employee disclosed, threatened to disclose, provided testimony regarding, objected to, or refused to participate in.

34:19-6. Fees, costs to employer. A court, upon notice of motion in accordance with the Rules Governing the Courts of the State of New Jersey, may also order that reasonable attorneys' fees and court costs be awarded to an employer if the court determines that an action brought by an employee under this act was without basis in law or in fact. However, an employee shall not be assessed attorneys' fees under this section if, after exercising reasonable and diligent efforts after filing a suit, the employee files a voluntary dismissal concerning the employer, within a reasonable time after determining that the employer would not be found to be liable for damages.

34:19-7 Posting of notices. An employer shall conspicuously display, and annually distribute to all employees, written or electronic notices of its employees' protections, obligations, rights and procedures under this act, and use other appropriate means to keep its employees so informed. Each notice posted or distributed pursuant to this section shall be in English, Spanish and at the employer's discretion, any other language spoken by the majority of the employer's employees. The notice shall include the name of the person or persons the employer has designated to receive written notifications pursuant to section 4 of this act. The Commissioner of Labor and Workforce Development shall make available to employers a text of a notice fulfilling the requirements of this section and provide copies of the notice suitable for display and distribution to any employers who request the copies, charging them as much as is needed to pay the costs of the department. The commissioner shall also provide notices printed in a language other than English and Spanish, at

the request of the employer. The requirement that an employer annually distribute to all employees written notices of the protections, obligations, rights and procedures provided to the employees by the provisions of P.L.1986, c.105 (C.34:19-1 et seq.) shall not apply to any employer who has less than 10 employees.

34:19-8. Other rights, remedies unaffected. Nothing in this act shall be deemed to diminish the rights, privileges, or remedies of any employee under any other federal or State law or regulation or under any collective bargaining agreement or employment contract; except that the institution of an action in accordance with this act shall be deemed a waiver of the rights and remedies available under any other contract, collective bargaining agreement, State law, rule or regulation or under the common law.

34:19-10 Required participation by employee in meetings, communications prohibited; exception. 2. No employer or employer's agent, representative or designee may, except as provided in section 3 of this act, require its employees to attend an employer-sponsored meeting or participate in any communications with the employer or its agents or representatives, the purpose of which is to communicate the employer's opinion about religious or political matters. This act shall not be construed as prohibiting an employer from permitting its employees to voluntarily attend employer-sponsored meetings or providing other communications to the employees, if the employer notifies the employees that they may refuse to attend the meetings or accept the communications without penalty.

34:19-11 Permitted communication about religious, political matters. 3. a. An employer or its agent, representative or designee may communicate to employees information about religious or political matters that the employer is required by law to communicate, but only to the extent required by law. b. Nothing in this act shall prohibit: (1) a religious organization from requiring its employees to attend an employer-sponsored meeting or to participate in any communications with the employer or its agents or representatives, the purpose of which is to communicate the employer's religious beliefs, practices or tenets; (2) a political organization or party from requiring its employees to attend an employer-sponsored meeting or to participate in any communications with the employer or its agents or representatives, the purpose of which is to communicate the employer's political tenets or purposes; or (3) an educational institution from requiring a student or instructor to attend lectures on political or religious matters that are part of the regular course work at the institution.

34:19-12 Retaliation against complaining employee prohibited. 4. No employer or employer's agent, representative or designee shall discharge, discipline or otherwise penalize or threaten to discharge, discipline or otherwise penalize any employee because the employee, or a person acting on behalf of the employee, makes a good faith report, verbally or in writing, of a violation or suspected violation of this act.

34:19-13 Civil action by aggrieved employee. 5. Any aggrieved employee may enforce the provisions of this act by means of a civil action brought no later than ninety days after the date of the alleged violation in a court of competent jurisdiction. The court shall award a prevailing employee all appropriate relief, including any of the following which are applicable to the violation:

- a restraining order against any continuing violation;
- b. the reinstatement of the employee to

the employee's former position or an equivalent position and the reestablishment of any employee benefits and seniority rights; c. the payment of any lost wages, benefits or other remuneration; and d. the payment of reasonable attorneys' fees and costs of the action. In addition, the court may award the prevailing employee punitive damages not greater than treble damages, or an assessment of a civil fine of not more than \$1,000 for a first violation of the act and not more than \$5,000 for each subsequent violation, which shall be paid to the State Treasurer for deposit in the General Fund.

34:19-14 Construction of act. 6. Nothing in this act shall be construed to limit an employee's right to bring a common law cause of action against an employer for wrongful termination or to diminish or impair the rights of a person under any collective bargaining agreement.

TEXAS. Under **Title IV, Section 531.101**, the commission may grant an award to an individual who reports activity that constitutes fraud or abuse of funds in the state Medicaid program or reports overcharges in the program if the commission determines that the disclosure results in the recovery of an administrative penalty imposed under Section 32.039, Human Resources Code. The commission may not grant an award to an individual in connection with a report if the commission or attorney general had independent knowledge of the activity reported by the individual. The commission shall determine the amount of an award. The commission may also consider whether the individual participated in the fraud, abuse, or overcharge.

Under § **531.102**, the commission, through the commission's office of inspector general, is responsible for the investigation of fraud and abuse in the provision of health and human services and the enforcement of state law relating to the provision of those services. If a provider is suspected of fraud or abuse involving criminal conduct, the office must refer the case to the state's Medicaid fraud control unit, provided that the criminal referral does not preclude the office from continuing its investigation of the provider, which investigation may lead to the imposition of appropriate administrative or civil sanctions, or if there is reason to believe that a recipient has defrauded the Medicaid program, the office may conduct a full investigation of the suspected fraud.

Under § **531.108**, the commission's office will ensure that a toll-free hotline for reporting suspected fraud in programs administered by the commission or a health and human services agency is maintained and promoted, either by the commission or by a health and human services agency.

Under § **554.002**, a state or local governmental entity may not suspend or terminate the employment of, or take other adverse personnel action against, a public employee who in good faith reports a violation of law by the employing governmental entity or another public employee to an appropriate law enforcement authority. In this section, a report is made to an appropriate law enforcement authority if the authority is a part of a state or local governmental entity or of the federal government that the employee in good faith believes is authorized to: regulate under or enforce the law alleged to be violated in the report; or investigate or prosecute a violation of criminal law. Under § **554.003**, a public employee whose employment is suspended or terminated or who is subjected to an adverse personnel action in violation of § **554.002** is entitled to sue for: injunctive relief; actual damages; court costs; and reasonable attorney fees. In addition to relief under Subsection (a), a public employee whose employment is suspended or terminated in violation of this

chapter is entitled to: reinstatement to the employee's former position or an equivalent position; compensation for wages lost during the period of suspension or termination; and reinstatement of fringe benefits and seniority rights lost because of the suspension or termination. In a suit against an employing state or local governmental entity, a public employee may not recover compensatory damages for future pecuniary losses, emotional pain, suffering, inconvenience, mental anguish, loss of enjoyment of life, and other nonpecuniary losses in an amount that exceeds certain statutory limitations.

Fraud and Abuse Procedures

Merit and each Merit hospital uses a variety of procedures to prevent fraud, waste and abuse including but not limited to: (a) establishing a toll-free Compliance Hotline to receive questions about compliance practices and reports of suspected improper or illegal activities; (b) conducting periodic compliance audits; (c) implementation of procedures for detected offenses that include reviewing potential wrongdoing allegations arising from the Compliance Hotline, informal communications, or audits; investigating, documenting, and providing written results of the investigation to executive management; and taking prompt corrective action, where appropriate; conducting new employee and periodic training on general compliance issues and targeted areas that require supplemental training; (d) implementing procedures to screen new employees for criminal or fraudulent histories; (e) and implementing other policies and procedures as needed. For further discussion of these procedures, see the related section of the Compliance Plan.