Fraud, Waste and Abuse

Policy Scope:
This policy applies to the AHN entities and individuals as outlined in the Policy Applicability section of this policy.

Policy Purpose
The purpose of this policy is to outline the requirements of federal and state laws that prohibit the submission of false claims and false statements in connection with federal and state health care programs, including Medicare and Medicaid. This policy applies to all workforce members as well as contractors and vendors within the Allegheny Health Network and its owned and controlled hospitals, affiliates and subsidiaries, including but not limited to those on Appendix A.

Policy Statement
It is the policy of the Allegheny Health Network to comply with the requirements of the Deficit Reduction Act of 2005 (DRA) and its obligations related to Fraud and Abuse under its state and federal contracts. Under this law, any entity who receives more than $5 million per year in Medicaid payments is required to provide information to its workforce members about the Federal False Claims Act, any applicable state False Claims Acts, the rights of workforce member to be protected as whistleblowers, and the organization's policies and procedures for detecting and preventing fraud, waste and abuse.

Policy Definitions:
Below is a summary of laws and regulations that Allegheny Health Network and its workforce members must be educated on and comply with. These laws apply to all workforce members, contractors and vendors at the Allegheny Health Network.

Federal False Claims Act:
The False Claims Act (FCA) is a federal statute that imposes civil penalties on any person or entity who:

• Knowingly submits a false claim to the government including Medicare and Medicaid for payment;
• Knowingly makes or uses a false record or statement to obtain payment or approval of a claim by the government including Medicare and Medicaid; and/or
• Uses a false statement to decrease an obligation to the government including Medicare and Medicaid.
A false claim may be found if the party submitting the claim had knowledge of the information and acted in deliberate ignorance or reckless disregard of the truth or falsity of the information.

**Article XIV of Public Welfare Code**

**This code prohibits:**

- any person from knowingly or intentionally submitting (or causing to be submitted), presenting for allowance, approval or payment, any false or fraudulent claim or cost report for furnishing services or merchandise under medical assistance, the state Medicaid program, the federal government or its agents, such as a Medicare Administrative Contractor or other claims processor.
- knowingly presenting for allowance or payment any claim or cost report for medically unnecessary services or merchandise under medical assistance, or to knowingly submit false information, for the purpose of obtaining greater compensation than that to which he is legally entitled for furnishing services or merchandise under medical assistance.
- knowingly submitting false information for the purpose of obtaining authorization for furnishing services or merchandise under medical assistance.
- any person from knowingly or intentionally making, using, or causing to be made or used, a false statement or misrepresentation or to willfully fail to disclose a material fact regarding eligibility, including, but not limited to, facts regarding income resources or potential third-party liability, for either themselves or any other individual, either prior to or at the time of or subsequent to the application for any medical assistance benefits or payments, or to conceal, avoid, or decrease an obligation to pay or transmit money or property to the U.S. government.
- knowingly making or using (or causing to be made or used) a false record or statement to get a false or fraudulent claim paid or approved by a state Medicaid program, the federal government or its agents, such as a fiscal intermediary or other claims processor.

**Civil Monetary Penalties:**

Civil penalties can be imposed on any person or entity that violates the federal False Claims Act, including monetary penalties of $5,500 to $11,000 per claim as well as damages of up to three times the federal government's damages resulting from each false claim.

"Whistleblower" and Whistleblower Protections:

The False Claims Act permits private citizens with knowledge of fraud or attempted fraud against the U.S., State or local government to file suit on behalf of the federal or state government against the person or business that committed or attempted the fraud. If the action is successful, the individual who brought the lawsuit – known as a "qui tam" plaintiff or a "whistleblower" – is entitled to a percentage of the amount recovered.

- The federal and state False Claims Acts afford protection to workforce members who make a good faith report of wrongdoing or waste, verbally or in writing, to one of the workforce member's supervisors, a compliance resource person, to an agent of your employer or to an appropriate authority.
- These protections prevent an employer or an agent of the employer from discharging, threatening or otherwise discriminating or retaliating against a workforce member's compensation, terms, conditions, location, or privileges of employment because the workforce member or a person acting on behalf of the workforce member makes a good faith report or is about to report, verbally or in writing to the employer or appropriate authority of wrongdoing or waste.
- Any manager, supervisor or workforce member who engages in such retaliation or harassment is subject to discipline, up to and including termination.
Program Fraud Civil Remedies:

The Federal Program Fraud Civil Remedies Act of 1986 allows the government to impose civil penalties against any person who makes, presents or submits (or causes to be made, presented or submitted) false, fictitious or fraudulent claims or written statements to designated federal agencies, including the U.S. Department of Health and Human Services.

Anti-Kickback Statutes:

These statutes prohibit any type of offer or payment of any remuneration, whether paid "directly or indirectly, overtly or covertly, in cash or in kind," that is knowingly and willfully intended to induce someone to refer Medicare, Medicaid, or other federal health program patients or to purchase, order, or recommend any item or service reimbursable by a federal health program.

- Remuneration is defined as a payment, kickback, gift, or bribe in the form of cash, services, or equipment.
- A violation of this prohibition can result in imprisonment, civil fines, exclusion from the Medicare and Medicaid programs and loss of medical license.
- "Safe Harbors" are provisions of federal law that protect business practices and relationships under the Anti-Kickback Statutes. These Safe Harbors include certain lease arrangements, personal service contracts and management agreements.

Stark Act:

This federal law prohibits physicians from referring a Medicare or Medicaid patient to an entity furnishing certain types of services known as "designated health services," (e.g. any/all inpatient and outpatient services) if the physician or an immediate family member of the physician has a direct or indirect financial interest in the entity unless an exception applies (e.g. employment, group practice, in-office ancillaries) as determined by the Statute. A financial interest includes an ownership interest or compensation arrangement.

Pennsylvania's Medicaid Fraud and Abuse Control Laws:

Many states, including Pennsylvania, have enacted laws to supplement the federal restrictions on Medicare and Medicaid patients. In particular, Pennsylvania's Medicaid Fraud & Abuse Control laws ban the following arrangements by or with providers:

- The referral of medical assistance patients for financial consideration, or the solicitation of such an arrangement;
- The offering or paying of remuneration for referrals of patients for service or supplies;
- The execution of a rent or lease arrangement unless the space is leased for fair market value;
- The solicitation or receipt of a kickback, payment, gift, bribe or rebate with regards to a good, facility, service or item for which payment is made under a state medical assistance program; and
- The referral of medical assistance patients to independent laboratories, pharmacies, radiology, or other ancillary medical service facilities in which the physician or group has an ownership interest.

Pennsylvania law also requires providers to disclose to patients a financial or ownership interest in the facility to which the patient is referred. The providers may render recommendations felt to be appropriate, but the patient must ultimately be advised of his or her freedom of choice in selecting the facility.

Workforce Members: Board of Directors, officers, employees, non-employed medical and allied health staff, students, and volunteers of Allegheny Health Network.
Guidelines/Procedures:

1. **Workforce Members, Contractor and Vendor Responsibilities:** Workforce members, contractors and vendors will comply with Allegheny Health Network Code of Business Conduct and policies and procedures which:
   a. Prohibits the submission of false claims and false statements;
   b. Requires the reporting of any suspected misconduct.
      i. Reports can be made to the Integrity & Compliance Department, the Compliance Officer, your supervisor/manager, or to the hotline at 1-877-867-7325. Information may be reported to the hotline anonymously.
   c. Prohibits retaliation against workforce members who, in good faith, report, file or participate in a whistleblower action as permitted by the federal False Claims Act.

2. **Manager’s Responsibilities:**
   a. Allegheny Health Network managers will assist with educating their workforce members on this policy and that Allegheny Health Network does not tolerate or condone activities that result in or contribute to the submission of false claims or statements to any federal or state health care programs, including Medicare and Medicaid.
   b. Managers must take appropriate action if he or she learns about possible fraudulent or abusive activities and report the activities to the Integrity & Compliance Department, the Compliance Officer, or to the hotline at 1-877-867-7325.

3. **Allegheny Health Network Responsibilities:**
   a. The Integrity and Compliance Program provides for internal investigations and prompt resolution of alleged violations. Depending on the nature of the violation, investigations of compliance issues may be performed by Integrity and Compliance staff or Human Resources.
   b. Allegheny Health Network engages in activities such as auditing, monitoring, and other oversight activities to identify compliance issues. Allegheny Health Network has procedures for conducting a timely, reasonable investigation into potential issues or violations to ensure prompt response to compliance concerns and develops corrective action plans if needed. Allegheny Health Network also has a program in place to identify, detect, prevent and reduce fraud, waste, and abuse.
   c. Allegheny Health Network works to ensure corrective action initiatives are taken, implemented, and the detected offenses are corrected. This method tracks and documents the correction of any underlying problems and helps to prevent future issues. Furthermore, any FWA-related concerns that impact Medicare business will be reported directly.
   d. Allegheny Health Network educates and trains Allegheny Health Network workforce members about the False Claims Act and all whistleblower protections under these laws.
   e. This policy will be available to all workforce members.
   f. Violations of this policy and/or procedure may result in corrective action, up to and including termination of employment.

4. **Integrity & Compliance Department Responsibilities:**
   a. The Integrity & Compliance Department is responsible for the establishment and maintenance of systems to track FWA case activity and referrals as necessary, processes to ensure appropriate
reporting to the required departments, committees and governing bodies as necessary, reporting of potential FWA cases and data to the appropriate CMS Medicare Integrity Contractor / Medicare Advantage Plan Sponsor, monitoring of any new FWA guidance from CMS and communication to various Company departments.

**Sponsorship and Authorizations**

A. Policy Sponsor: Compliance Officer  
B. Policy Authority: Vice President, Provider Financial Operations

**Cross Referenced and Related Policies**

1. Allegheny Health Network- Code of Business Conduct  
2. Westfield Memorial Hospital Corporate Compliance Detection and Prevention, Fraud, Waste and Abuse policy

**External and Regulatory References**

1. Federal False Claims Act: https://oig.hhs.gov/authorities/docs/06/waisgate.pdf  
3. Civil Monetary Penalties: https://oig.hhs.gov/fraud/enforcement/cmp/background.asp  
5. Anti-Kickback Statute: https://oig.hhs.gov/compliance/safe-harbor-regulations/  
7. Pennsylvania's Medical Fraud and Abuse Control Laws  
9. New York State laws description: http://www.omig.state.ny.us/data/content/view/81/65/

**Attachment**

**Policy Applicability**

**Attachments:**

- A: Policy Applicability
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<th>Approver</th>
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<td>CEO Approval</td>
<td>Scott Whalen: President &amp; CEO</td>
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<td>William Englert: PRESIDENT AND CEO AVH</td>
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<td>Ron Andro: PRESIDENT AND CEO WPH</td>
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<td>Angela Costa: VP PATIENT CARE SERVICES &amp; CNO</td>
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