

Care Initiatives Policy and Procedure

TITLE: False Claims Act & Whistleblower Protection Information and Education

PURPOSE:

To satisfy requirements to provide information and education about False Claims Recovery to Care Initiatives (CI) employees, contractors and agents pursuant to Section 6032 of the Deficit Reduction Act of 2005 (DRA) which establishes Section 1902(a)(68) of the Social Security Act.

POLICY:

CI is committed to its role in preventing health care fraud and abuse and complying with applicable state and federal law related to health care fraud and abuse. The DRA requires our organization to provide information and education concerning the federal False Claims Act and other laws, including state laws, dealing with fraud, waste, and abuse and whistleblower protections for reporting those issues. This policy provides detailed information on the following:

- The Federal False Claims Act under title 31 of the United States Code, sections 3729 through 3733;
- Administrative remedies for false claims and statements under title 31 of the United States Code, chapter 38;
- Iowa law pertaining to civil or criminal penalties for false claims and statements (*Iowa Code 249A and 685 and Iowa Code sections 714.8(10)-714.14*); and
- Whistleblower protections under such laws.

PROCEDURE:

1. Care Initiatives shall disseminate this policy and/or otherwise make detailed information or references, regarding the federal and state laws, readily available to its employees, contractors, and agents through one or more of the following:
 - a. on its organizational website;
 - b. in its Employee Handbook;
 - c. in a “*DRA Quick Guide*” reference;
 - d. in contract language; and/or
 - e. on paper copy upon request.

2. The detailed information includes the following:

FALSE CLAIMS ACT (FCA) AND WHISTLEBLOWER PROTECTIONS

When a person deliberately uses a misrepresentation or other deceitful means to obtain something to which he or she is not otherwise entitled, that person has committed fraud. The False Claims Act makes it illegal for someone to present false written statements to the Government to improperly obtain more money from (or in some cases pay less money to) the Government than actually owed by (or due from) that person or company. Examples of common fraud on the government include but are not limited to:

- Billing for items or services not actually rendered;
- Providing medically unnecessary services;

- Creating false documentation to support a bill;
- Using a billing code that provides a higher payment rate than the billing code which actually reflects the service provided;
- Submitting more than one claim for the same service; or
- Ignoring a known or suspected violation that would lead to a false claim being submitted.

Under the FCA, the person or company accused of fraud doesn't have to actually know that the information it provided to the Government was false. It is sufficient that the person or company supplied the information to the Government either: (i) in "deliberate ignorance" of the truth or falsity of the information; or (ii) in "reckless disregard" of the truth or falsity of the information. In other words, the FCA is not limited solely to those who intentionally misrepresent facts in order to obtain payments or other benefits from the Government; it also covers reckless conduct. Thus, if a person or company *should have known* that its representations to the Government were not true or accurate, but did not bother to check, such recklessness may constitute a violation of the FCA. Likewise, if a person or company deliberately ignores information that may lead to discovery of a false statement, that decision represents "deliberate ignorance" and could constitute a violation of the FCA. The FCA makes no distinction between intentional fraud and reckless fraud; both are illegal. The same penalties may be assessed against the wrongdoer.

The FCA also holds those persons responsible if they "caused" misrepresentations to be made to the Government by others. In other words, a person may violate the FCA even if he or she does not actually submit the false information to the Government, but instead creates or provides false information that is then submitted to the Government by another.

The monetary penalties for violating the FCA are between \$5,500 and \$11,000 per false claim submitted, plus damages amounting to three times what is owed back to the government, plus the costs associated with litigation to recover the lost money.

The FCA is also known as a "Whistleblower" law in the U.S. "Whistleblowing" is generally defined as the disclosure by a person of mismanagement, corruption, illegality, or some other wrongdoing concerning the use of government funds. The person making the disclosure is often referred to as the "Whistleblower". The FCA permits any person who discovers a fraud on the federal government to report it through the law's specialized procedures. If the government collects from the fraudulent provider, it permits the whistleblower to share in the proceeds recovered.

Beyond permitting the Whistleblower to receive a portion of recovered funds, the FCA also provides protection to employees who are retaliated against by an employer because of the employee's participation in a "Whistleblower" action. This protection is available to any employee who is fired, demoted, threatened, harassed or otherwise discriminated against by his or her employer because the employee investigates, files or participates in a FCA action. This "Whistleblower" protection includes reinstatement and damages of double the amount of lost wages if the employee is fired, and any other damages sustained if the employee is otherwise discriminated against.

IOWA FALSE CLAIMS ACT & ACCOMPANYING STATE FRAUD LAWS

Iowa Code § 685: The Iowa “False Claims Act” adopts definitions, practices, penalties and protections similar to the Federal False Claims Act.

Iowa Code § 249A: The Iowa “Medical Assistance Act” adopts definitions, practices, penalties and protections addressing fraudulent practice under the Iowa medical assistance program (i.e. Medicaid). Specifically, a person who knowingly makes or causes to be made false statements or misrepresentations of material facts or knowingly fails to disclose material facts in applications for payment for services or merchandise rendered or purportedly rendered by a provider participating in the medical assistance program commits a fraudulent practice.

Iowa Code § 714: The Iowa Code “Theft, Fraud & Related Offenses” adopts definitions and degrees of criminal penalties associated with fraudulent activity by individuals.

PREVENTING & DETECTING FRAUD, WASTE, & ABUSE

PREVENTION

Commitment to Organizational Mission & Core Values

Care Initiatives Mission & Core Values demonstrate the commitment the organization makes to maintain the highest level of professional and ethical standards in delivering quality health care services to its customers. Consistent with these organizational commitments, Care Initiatives has developed practices in its billing preparation and submission to prevent and detect fraud, abuse and waste in programs funded by Medicare and Medicaid and/or other government programs.

Corporate Compliance Program

Care Initiatives maintains a Corporate Compliance Program that is consistent with federal requirements and guidance issued by the U. S. Department of Health and Human Services Office of Inspector General. The Care Initiatives Corporate Compliance Program provides guidance to workforce members, including management, on their responsibilities and to help them determine appropriate conduct in performing their duties. Our company has established a Compliance Officer and compliance committee within the Board of Directors to oversee and monitor the implementation of the Corporate Compliance Program. All Care Initiatives’ employees/contractors/agents are obligated to follow the compliance policies and procedures, which include a written Standards of Conduct available on the organization’s public website.

Orientation & Training Program

Care Initiatives operational managers are responsible to implement effective orientation and training to promote accurate clinical documentation and maintenance of supportive billing records. Care Initiatives must provide proper training and resources to its workforce to promote compliance with applicable federal and state laws, including laws, regulations, and policies. Employee/contractors/agents are required to seek guidance from a supervisor or the Care Initiatives’ Compliance Officer when questions or concerns arise.

Policies Prohibiting False or Fraudulent Claims

Care Initiatives prohibits any employee, contractor or agent from knowingly presenting a claim for payment or approval that is inaccurate, false, fictitious or fraudulent. Compliance with this standard is an important factor in evaluating the performance of an employee or the ongoing relationship with a contractor or agent. Employees, contractors or agents who fail to comply with this standard will be subject to additional training and/or appropriate corrective action.

Effective Enforcement of Standards

Care Initiatives' employees who violate the Corporate Compliance Program policies or other organizational policies may be subject to corrective action and/or retraining to prevent recurrence of the violation. In determining the level of corrective action to be taken, management will consider the amount of prior training provided to the involved employee(s). The corrective action imposed will depend on the nature, severity and frequency of the violation and may result in any of the permitted corrective actions as provided by law.

DETECTION

Personal Obligation to Report

Each employee, contractor and agent has an individual responsibility to report any activity by any Care Initiatives' employee, contractor, agent or vendor that the individual has reason to believe violates applicable laws, rules, regulations or the compliance program standards. All violations or suspected violations believed to be fraudulent or a violation of the compliance program shall be reported immediately to the Compliance Officer with concurrent notification to the employee's supervisor or to the Compliance Officer alone, if circumstances justify it. Individuals who, in good faith, report a possible violation will not be subjected to retaliation. However, employees who make a report that they know to be false or misleading will be subject to appropriate corrective action.

Whistleblower Protection

Care Initiatives (CI) prohibits retaliation and will take no adverse action against persons for making reports in good faith ("Whistleblowers"), even if the investigation finds the report not substantiated. Retaliation and adverse action include the following: discharge, demotion, suspension, denial of promotion, transfer or in any other manner discriminating or threatening to discriminate against a staff member in the terms and conditions of the staff member's employment. Any staff member who believes that he/she has been subjected to or affected by retaliatory conduct for reporting a known/suspected violation or for refusing to engage in activity that would be a violation, should report such retaliation to the CI Corporate Compliance Department. The Corporate Compliance Officer will be responsible for investigation of such report or referring the report to the appropriate CI Department leadership, such as Human Resources, for prompt investigation.

Internal Investigation & Follow Up of Reports

Care Initiatives is committed to investigating all reported concerns of billing fraud, waste, or abuse promptly and confidentially to the extent possible. The Compliance Officer will coordinate investigations with proper department supervisors, including outside legal counsel, and shall report any findings of a violation to the Board of Directors and Executive Officers of Care Initiatives. Furthermore, proper reporting, including self-reporting to appropriate oversight agencies, shall occur if circumstances warrant. Such agencies may include Office of the Inspector General, Centers for Medicare or Medicaid (CMS), Medicare Approved Contractors

(MAC) and/or State Department of Inspections & Appeals. Recommended corrective actions may accompany such reports. It is Care Initiatives' expectation that all employees shall cooperate with investigation efforts.

Self-Reporting and/or Resolution of Identified Overpayments

When an internal investigation concludes that a violation of billing practices has led to a clear identification of an overpayment from a government health care program, it is the policy of Care Initiatives to initiate appropriate corrective action, including but not limited to, making prompt self-reporting to the appropriate government agency, provide restitution of identified overpayment amounts and/or implementing systemic changes to prevent a similar violation from recurring in the future.

Internal Audit and other Monitoring

Care Initiatives is committed to the monitoring of compliance with its policies. Much of this monitoring effort will be conducted through operational management review. In addition, the Compliance Department will conduct internal audits, which may be directed by legal counsel on occasion, consistent with its audit work plan and as directed by the Board Compliance Committee. Internal audits and monitoring will involve direct efforts of the Compliance Department that may or may not include delegation of duties to various corporate and facility departments such as Operations, Finance, Human Resources and/or Quality Assurance.

NON-RETALIATION

CI does not tolerate retaliation by any employee(s) against another employee for good faith reports of suspected noncompliance with company policies or potential violations of the compliance program. It is the established policy of CI that it will not retaliate against or otherwise discipline any individual simply because he or she reports suspected misconduct or noncompliance.

Employee Education Concerning Retaliation

In an effort to make this policy known, CI will make it clear to all employees at the time of their initial orientation and through periodic training thereafter that it will be a violation of the Compliance Program to intimidate or impose any other form of reprisal or retaliation on any employee or agent who uses the compliance reporting mechanism for its intended purposes.

Employee Encouragement to Communicate Policy Concerns

All personnel are encouraged to report their concerns if they believe that patient/resident care is at risk or the ethical and business standards defined in the code have not been met. CI is committed to fostering dialogue between management and employees. Our goal is that all employees, when seeking answers to questions or reporting potential instances of fraud and abuse, should know whom to turn to for a meaningful response and should be able to do so without fear of retribution.

Corporate Compliance Officer Audit & Review of Retaliation Policy

The Corporate Compliance Officer (CCO) is charged with assuring effective organizational policies regarding employee retaliation are established and maintained. To that end, the CCO may take those actions necessary to conduct audit and review of application of the Non-Retaliation policies for the company. Such acts may include a review of personnel records and other information periodically to ensure that those who report suspected misconduct or noncompliance are not the victims of retaliation, retribution or other improper conduct. In addition, the CCO shall have the authority to keep the names of CI personnel confidential. The CCO does not, however, have the authority unilaterally to extend any protection or immunity from disciplinary action or prosecution to CI personnel who have engaged in misconduct or noncompliance.

Effective date and changes to the Terms of this Policy.

This policy is effective December 15th, 2015. Last reviewed on July 15, 2024.