False Claims Prevention

POLICY STATEMENT

It is the policy of Atrium Health & Senior Living ("Atrium") to put into practice procedures designed to detect and prevent fraud, waste and abuse, and to maintain policies to protect from retaliation those who report, in good faith, any concerns of actual or suspected wrongdoing.

SCOPE

This policy applies to all team members (including Management), contractors and agents of Atrium Health & Senior Living.

PURPOSE

The purpose of this policy is to promote the integrity of all claims for reimbursement submitted by Atrium, to ensure compliance with all applicable Federal and State laws designed to prevent fraud, waste and abuse in publicly funded health care programs summarized below, and to ensure that those who in good faith report known or suspected violations of these laws are protected from retribution or retaliation for doing so.

SUMMARY OF FEDERAL AND STATE LAWS

A. Federal False Claims Act, 31 U.S.C. §§3729-3733

The Federal False Claims Act imposes liability on any person who:

(i) knowingly files a false or fraudulent claim for payment to Medicare, Medicaid, or any other federally funded health care program;

(ii) knowingly uses a false record or statement to obtain payment on a false or fraudulent claim from Medicare, Medicaid, or any other federally funded health care program; or

(iii) knowing and improper retention of an overpayment; or

(iv) does any of the above to obtain federally funded health care program money regardless of whether the claim was submitted directly to the government; or

(v) conspires to violate any requirement of the Federal False Claims Act.

"Knowingly" means (1) having actual knowledge that the information on the claim is false; (2) acting in deliberate ignorance of whether the claim is true or false; or (3) acting in reckless disregard of whether the claim is true or false.

A person or entity found liable under the Federal False Claims Act is generally subject to civil money penalties of between $5,500 and $11,000 per claim plus three times the amount of damages that the government sustained because of the illegal act plus the government cost in recovering penalties and damages. In health care cases, the amount of damages sustained is the amount paid for each claim that is filed that is determined to be false.

Anyone may bring a *qui tam* action under the Federal False Claims Act in the name of the United States. The case is initiated by filing the complaint and all available material evidence under seal with a federal court. The complaint remains under seal for at least 60 days and will not be served on the defendant. During this time, the government investigates the complaint.

The government may also request additional investigation time beyond 60 days. After expiration of the review and investigation period, the government may elect to pursue the case in its own name or decide not to pursue the case. If the government decides not to pursue the case, the person who filed the action has the right to continue with the case on his or her own.

If the government proceeds with the case, the person who filed the action will generally receive between 15% and 25% of any recovery, depending on the contribution of that person to the prosecution of the case. If the government does not proceed with the case, the person who filed the action will be entitled to between 25% and 30% of any recovery, plus reasonable expenses and attorneys‟ fees and costs.

B. Federal Program Fraud Civil Remedies Act, 31 U.S.C. §§3801-3812

The Federal Program Fraud Civil Remedies Act ("PFCRA") creates administrative remedies for making false claims and false statements. These penalties are separate from and in addition to any liability that may be imposed under the False Claims Act.

The PFCRA imposes liability on people or entities that file a claim that they know or have reason to know:

(i) is false, fictitious, or fraudulent;

(ii) includes or is supported by a written statement that contains false, fictitious, or fraudulent information;

(iii) includes or is supported by a written statement that omits a material fact, which causes the statement to be false, fictitious, or fraudulent, and the person or entity submitting the statement has a duty to include the omitted fact; or

(iv) is for payment for property or services not included as claimed.

A violation of this section of the PFCRA is punishable by a $5,000 civil penalty for each wrongfully filed claim, plus an assessment of twice the amount of any unlawful claim that has been paid. In addition, a person or entity violates the PFCRA by submitting a written statement that the person or entity knows or should know (i) asserts a material fact that is false, fictitious, or fraudulent; or (ii) omits a material fact they had a duty to include, the omission caused the statement to be false, fictitious, or fraudulent, and the statement contained a certification of accuracy. A violation of this section of the PFCRA carries a civil penalty of up to $5,000 in addition to any other remedy allowed under other laws.

C. PROTECTIONS AGAINST RETALIATION

Individuals within an organization who observe activities or behavior that may violate the law in some manner and who report their observations either to management or to governmental agencies ("Whistle Blowers") are provided protections under federal and state law. For example, the Federal False Claims Act includes protections for people who file *qui tam* lawsuits as described previously.

The Federal False Claims Act states that any team member who is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment because of lawful actions taken in furtherance of a qui tam action is entitled to recover damages, as well as all relief necessary to make the team member whole, including two times the amount of back pay owed to the team member. The team member can also be awarded litigation costs and reasonable attorneys' fees.

A. The Federal False Claims Act also provides that team members, agents and contractors engaged in other efforts to stop a violation of the Federal False Claims Act may recover damages for retaliation against them that occurs because of those efforts.

B. As set forth in the State Law Supplement, below, certain state laws provide similar protections against retaliation for "Whistle Blowers."

Available remedies for retaliation against "Whistle Blowers" may include an injunction restraining a continuing violation, reinstatement of the team member including full fringe benefits and seniority rights, compensation for lost wages, benefits, and other remuneration, punitive damages, civil fine, and payment by the employer of reasonable litigation costs and attorneys' fees.

D. State Law Supplements

NEW JERSEY

MICHIGAN

WISCONSIN

E. ROLE OF FALSE CLAIMS LAWS

The false claims laws discussed above are an important part of preventing and detecting fraud, waste, and abuse in federal and state health care programs because they provide governmental agencies the authority to seek out, investigate, and prosecute fraudulent activities. Enforcement activities take place in the criminal, civil, and administrative arenas. This provides a broad spectrum of remedies to combat these problems. Anti-retaliation protections for individuals who make good faith reports of waste, fraud, and abuse encourage reporting and provide broader opportunities to prosecute violators. Statutory provisions, such as anti-retaliation provisions of the Federal False Claims Act, create reasonable incentives for this purpose. Employment protections create a level of security team members need in order to help in prosecuting these cases.

PROCEDURE

PROCEDURES FOR DETECTING AND PREVENTING FRAUD, WASTE AND ABUSE

Any team member who knows of or reasonably suspects an incident of fraud, waste, or abuse regarding Medicare, Medicaid, or any other federal or state health care program, or a violation of any of the laws outlined in this policy, by any Atrium Health and Senior Living team member, supervisor, contractor or agent is required to immediately report such incident to their Department Head/Supervisor or Administrator/Executive Director. Reports may also be made directly to the Atrium Health and Senior Living Commitment Line at 1-855-600-5850 if a team member has concerns about reporting the incident to their Department Head/Supervisor and/or the Administrator/Executive Director. Likewise, any team member of a contractor, vendor or agent of Atrium Health and Senior Living who has concerns about the work he or she performs should report these concerns to Atrium Health and Senior Living's Commitment Line at 1-855-600-5850.

Atrium Health and Senior Living will not tolerate any intimidating or retaliatory act against an individual who in good faith reports practices reasonably believed to be a violation of this policy.

Atrium Health and Senior Living will make this policy available to all team members, including management, as well as all contractors and agents. Furthermore, Atrium Health and Senior Living will maintain its internal systems and controls to monitor its coding and billing practices on an ongoing basis to ensure compliance with the laws outlined in this policy.

A background screening will include verifying that an individual has not been excluded from participation in state or federally funded health benefit programs, such as Medicare or Medicaid ("excluded individuals or entities"). It may also include verifying that an individual license is not revoked, suspended or under review or lapsed. Atrium will monitor various state and federal databases at the time an offer is made and on a monthly basis thereafter to ensure that required licenses are current and unencumbered, and to prevent the employment or retention of "excluded individuals or entities."

RESPONSIBLITIES

Obligation to Report Violations or Suspected Violations

All Atrium team members should promptly report any activity by fellow team members, physicians, contractors, vendors, or others that involves actual or suspected violations of laws summarized above pertaining to fraud, waste or abuse, related regulations, Atrium policies, or the Atrium Code of Conduct. Team members who fail to promptly report actual or suspected violations may be subject to disciplinary action up to and including termination.

Reporting Methods

Team members seeking guidance on any compliance issues or wishing to report actual or suspected violations of the law, regulations, policies, or the Code of Conduct have several options. First, team members are encouraged to discuss the situation with their Department Head/Supervisor. If team members are uncomfortable talking to their Department Head/Supervisor or do not receive a satisfactory response, a second option is to contact the Administrator/Executive Director or Commitment Line at 1-855-600-5850. Team members may also write to the Atrium Health and Senior Living Human Resources Department, 150 Clove Road, 7th Floor, Little Falls, New Jersey, 07424. Team members making written reports are to describe the circumstances as they know them and include any relevant documents relating to the suspected violations. The envelope is to be marked "For Compliance/Personal and Confidential."

Additional reporting resources include the Centers for Medicaid and Medicare Services at 1-800-447-8477 or state resources set forth in the State Law Supplement accompanying this policy.

Confidentiality of Reports

Atrium Health and Senior Living will make every effort to keep the identity of the team member and the contents of the team member reports confidential, to the extent consistent with a thorough investigation and the requirements of state and federal law.

Protection of Reporting Team Member

Atrium Health and Senior Living will not tolerate any retaliation against team members who make good faith reports of violations, or potential violations of laws, regulations, policies, or any element of the Atrium Compliance Program. Team members who attempt to retaliate against the reporting team member(s) will be subject to disciplinary action. Additionally, team members who make knowingly false reports with the intent to harm or retaliate against other team members may be subject to disciplinary action. Atrium Health and Senior Living takes very seriously the many federal and state laws that protect team members when the team member makes good faith reports involving what the team member reasonably believes to be violations of laws, regulations, policies, or the Compliance Program.

Investigation of Reports

Upon receipt of a report, an internal investigation that is appropriate under the circumstances will be conducted.

Corrective Action

If the internal investigation substantiates a violation, corrective action will be taken, including, as appropriate, prompt restitution of any overpayments, notice to appropriate governmental agencies, disciplinary action, and changes in policies and procedures to prevent a recurrence.

Discipline for Violations

Violations of the Compliance Policies will not be tolerated. Based on the internal investigation, disciplinary action may be imposed for any violation of this policy up to and including termination in accordance with applicable Atrium Human Resources policies and procedures. recommended for any of the following;

Compliance Committee

The Compliance Committee and Compliance Officer(s) are responsible for ensuring that the policies, procedures and other mechanisms to identify and prevent the filing of false claims by or on behalf of Atrium entities referenced above remain effective and current with all applicable state and federal laws.

DEFINITIONS

FORMS

Vendor Compliance Disclosure and Attestation Form

INSTRUCTIONS

There are no instructions associated with this policy.

APPENDICES

There are no appendices associated with this policy.

ASSOCIATED POLICIES

Atrium Health & Senior Living Code of Conduct

NEW JERSEY STATE SUPPLEMENT TO THE FALSE CLAIMS PREVENTION POLICY

A. *New Jersey False Claims Act [N.J.S.A. 2A:32C-1–2A:32C-17 and N.J.S.A. 30:4D-17(e)]*

The New Jersey False Claims Act ("NJFCA") has similar provisions to the federal False Claims Act and is a state law that creates liability for any person who knowingly presents or causes to be presented a false or fraudulent claim to the State of New Jersey, or any contractor, grantee or other recipient of state funds, for payment from any state funded contract or program.

The NJFCA prohibits retaliation by Atrium Health and Senior Living against any team member for the disclosure of information regarding this law; thus, Atrium Health and Senior Living shall not discharge, demote, suspend, threaten, harass, deny promotion to, or in any other manner discriminate against a team member in the terms and conditions of employment because of the team member‟s good faith report to the State or law enforcement agency.

Remedies for retaliation include making a team member "whole" by reinstating him/her, paying him/her two times the amount of back pay, interest on the back pay, compensation for any special damage sustained as a result of the discrimination, including litigation costs and reasonable attorneys‟ fees, and, where appropriate, punitive damages.

Under the NJFCA, no employer shall make, adopt, or enforce any rule, regulation, or policy preventing a team member from disclosing information to a State or law enforcement agency or from acting to further a false claims action, including investigating, initiating, testifying, or assisting in an action filed or to be filed under this act.

Health care providers and suppliers who violate the NJFCA can be subject to civil monetary penalties ranging from $5,500 to $11,000 for each false claim submitted.

Violations of the NJFCA can also give rise to liability under the New Jersey Medical Assistance and Health Services Act (see below).

B. *New Jersey Medical Assistance and Health Services Act [N.J.S.A. 30:4D-1 et seq.]*

The New Jersey Medical Assistance and Health Services Act ("NJMAHSA") makes it a crime for:

- any person to willfully obtain benefits to which he or she is not entitled and any provider to willfully receive payments to which the provider is not entitled, and;
- a person, entity, or provider to:
    - knowingly and willfully make or cause to be made a false statement or representation of a material fact in any cost study, claim form, or document necessary to apply for or receive a benefit or payment under the NJMAHSA, or;
    - knowingly and willfully make or cause to be made a false statement of material fact for use in determining rights to such benefit or payment, or;
    - conceal or fail to disclose the occurrence of an event that affects the initial or continued right to any such benefit or payment with an intent to fraudulently secure benefits or payments not authorized under the NJMAHSA, or;
    - knowingly and willfully convert benefits or payments to a use other than for which they were received.

A conviction carries a penalty of up to $10,000 for the first and each subsequent offense and/or imprisonment for up to three (3) years.

In addition, any person, entity or provider who solicits, offers or receives any kickback, rebate or bribe in connection with the furnishing of items or services for which payment may be made or whose cost may be reported in order to obtain or in connection with the receipt of benefits/payments under the NJMAHSA, will be liable for a penalty of up to $10,000 and/or up to three (3) years imprisonment.

Whomever knowingly and willfully makes, causes to be made or induces or seeks to induce the making of a false statement of material fact with respect to conditions or operations of Atrium Health and Senior Living so that Atrium Health and Senior Living may qualify as a hospital, skilled nursing facility, intermediate care facility or health agency will be guilty of a high misdemeanor and will be liable for a penalty of up to $3,000 and/or up to one (1) year in prison.

Any person, entity or provider who violates any of the above provisions will also be liable for civil penalties of interest at the maximum legal rate on the benefits or payments, an amount of up to three times the amount of the benefits; and an amount equal to the civil money penalties provided for under the Federal False Claims Act, currently between $5,500 and $11,000 per improper claim for benefits or payment.

Any person, entity or provider who, without intent to violate the NJMAHSA, obtains benefits or payments in excess of the entitled amount, may be liable for a civil penalty of the payment of interest on the excess benefits or payments at the maximum legal rate. A provider or person participating in a benefit program or acting as an agent, team member or independent contractor of a provider may be suspended, debarred or disqualified for good cause.

C. *New Jersey Health Care Claims Fraud Act [N.J.S.A. 2C:21-4.2 and 4.3; N.J.S.A. 2C:51-5]*

The New Jersey Health Care Claims Fraud Act ("NJHCCFA") makes it a crime to submit false, fictitious, fraudulent or misleading statements of material fact in any document in connection with payment or reimbursement under a state-funded healthcare program. The law provides for the following criminal penalties:

- a second degree crime for any "practitioner" to knowingly commit health care claims fraud in the course of providing professional services, and
- a third degree crime for any "practitioner" to recklessly commit health care claims fraud in the course of providing professional services.

The NJHCCFA further makes it a third degree crime for non-practitioners to knowingly commit health care claims fraud, a second degree crime for non-practitioners to knowingly commit five or more acts of health care claims fraud if the aggregate pecuniary benefit obtained or sought is $1,000 or more, a fourth degree crime for non-practitioners to recklessly commit health care claims fraud.

The law defines "health care claims fraud" broadly as:

> 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.
>
> A person convicted under this statute may also be subject to a fine of up to $150,000 or five times the amount of damages for each false claim. Additionally, punishments can include prison terms of five (5) to ten (10) years for a practitioner and the claim is submitted in the course of providing professional services; or three (3) to five (5) years for non-practitioners who file a false claim.

D. New Jersey Uniform Enforcement Act [N.J.S.A. 45:1-21]

The New Jersey Uniform Enforcement Act is a state law that provides that a licensure board within the N.J. Division of Consumer Affairs "may refuse to admit a person to an examination or may refuse to issue or may suspend or revoke any certificate, registration or license issued by the board" who has engaged in "dishonesty, fraud, deception, misrepresentation, false promise or false pretense, or has "advertised fraudulently in any manner."

E. *New Jersey Consumer Fraud Act [N.J.S.A. 56:8-2, 56:8-3.1, 56:8-13, 56:8-14 and 56:8-15]*

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

Penalties include a fine of not more than $10,000 for the first offense and not more than $20,000 for the second and each subsequent offense. Restitution to the victim can also be ordered.

F. New Jersey Insurance Fraud Prevention Act [N.J.S.A.17:33A1 et seq.]

This law makes it unlawful to present or cause to be presented any written or oral statement regarding a claim for payment or other benefit pursuant to an insurance policy knowing the statement contains false or misleading information or conceals material information concerning any fact regarding the claim. The purpose of this law is to combat insurance fraud by facilitating the detection of insurance fraud, eliminating the occurrence of such fraud through the development of fraud prevention programs, requiring the restitution of fraudulently obtained insurance benefits, and reducing the amount of premium dollars used to pay fraudulent claims. A violation of this law can result in substantial civil damages and penalties as well as criminal prosecution.

Protections Against Retaliation

Individuals within an organization who observe activities or behavior that may violate the law in some manner and who report their observations either to management or to governmental agencies are provided protections under certain laws. For example, the Federal False Claims Act includes protections for people who file qui tam lawsuits as described previously.

The Federal False Claims Act states that any team member who is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment because of lawful actions taken in furtherance of a qui tam action is entitled to recover damages, as well as all relief necessary to make the team member whole, including two times the amount of back pay owed to the team member. The team member can also be awarded litigation costs and reasonable attorney‟s fees.

- The Federal False Claims Act also provides that team members, agents and contractors engaged in other efforts to stop a violation of the Federal False Claims Act may recover damages for retaliation against them that occurs because of those efforts.
- The New Jersey False Claims Act has whistleblower protections similar to those provided by the Federal False Claims Act.
- Likewise, the New Jersey Conscientious Employee Protection Act ("CEPA"), N.J.S.A. §§ 34:19-1, et seq., prohibits an employer from retaliating against a team member because the team member:
    i. discloses or threatens to disclose an activity that the team member reasonably believes violates the law, is fraudulent or criminal, or (for team members who are certified or licensed health care professionals) constitutes improper quality of resident or patient care;
    ii. provides information to or testifies before a public body conducting an investigation, hearing, or inquiry into any violation of law, or (for team members who are certified or licensed health care professionals) into the quality of resident or patient care; or
    iii. objects to or refuses to participate in an activity that the team member reasonably believes to be a violation of law, fraudulent, criminal, incompatible with a clear mandate of public policy, or (for team members who are certified or licensed health care professionals) improper quality of resident or patient care.

Available remedies may include an injunction restraining a continuing violation, reinstatement of the team member including full fringe benefits and seniority rights, compensation for lost wages, benefits, and other remuneration, punitive damages, civil fine, and payment by the employer of reasonable litigation costs and attorneys' fees.

Additional reporting resources include the New Jersey Medicaid Fraud and Abuse Hotline at 609-826-4701 or 1-888-937-2385 or the Centers for Medicaid and Medicare Services at 1-800-447-8477.

MICHIGAN STATE SUPPLEMENT TO THE FALSE CLAIMS PREVENTION POLICY

A. *Michigan Medicaid False Claims Act, Mich. Comp. Laws §§400.601-400.615*

In pertinent part, the state Medicaid False Claims Act prohibits any person from:

i. Knowingly or causing to be made a false statement or misrepresentation of a material fact in an application for Medicaid benefits, or with respect to the conditions or operation of an institution or facility in order that the institution may qualify, upon initial certification or recertification, as a hospital, skilled nursing facility, intermediate facility or home health agency; or

ii. Knowingly making or causing to be made a false statement or misrepresentation of a material fact for use in determining rights to Medicaid benefits or payments; or

iii. Having knowledge of the occurrence of an event affecting his initial or continued right to receive Medicaid benefits or payments or the initial, or continued right of any other individual on whose behalf someone has applied for or is receiving the benefits or payments, concealing or failing to disclose such event with an intent to obtain a benefit to which the person or any other person is not entitled or in an amount greater than that to which the person or any other person is entitled.

iv. Making or presenting or causing to be made or presented to an employee or officer of Michigan a claim under the Social Welfare Act, upon or against the state, knowing the claim to be false; making or presenting or causing to be made or presented a claim under the Social Welfare Act that s/he knows falsely represents that the goods or services for which the claim is made were medically necessary in accordance with professionally accepted standards (each claim violating this provision being a separate offense).

Anyone found guilty of the above may be imprisoned for up to four years, or fined not more than $50,000.00, or both.

Anyone who knowingly or causes a false statement to be made or misrepresents a material fact pertaining to the operation of an institution or facility in order that the institution may qualify, upon initial certification or recertification, as a hospital, skilled nursing facility, intermediate facility or home health agency may be imprisoned up to four years, or fined not more than $30,000.00 or both.

The state Medicaid False Claims Act further prohibits a person from soliciting, offering or receiving a kickback or bribe in connection with the furnishing of goods or services for which payment is or may be made in whole or in part pursuant to the Michigan Social Welfare Act 280 or 1939, as amended (Mich. Comp. Laws *§§* 400.1-400.121). Any person who makes or receives the payment, or who receives a rebate of a fee or charge for referring an individual to another person for the furnishing of the goods and services is guilty of a felony, punishable by imprisonment for not more than 4 years, or by a fine of not more than $30,000.00, or both.

A person who enters into an agreement, combination, or conspiracy to defraud the state by obtaining or aiding another to obtain the payment or allowance of a false claim under the Social Welfare Act is guilty of a felony, punishable by imprisonment for not more than 10 years, or by a fine of not more than $50,000.00, or both.

D. *Michigan Fraudulent Insurance Act, Mich. Comp. Laws §§500.4503-500.4511*

In pertinent part, the state Medicaid fraud statute prohibits any person from knowingly and with intent to injure, defraud or deceive:

(i) Presenting or causing to be presented or preparing with knowledge or belief that it will be presented to or by an insurer or any agent of an insurer, or any agent of an insurer, reinsurer, or broker any oral or written statement knowing the statement contains false information concerning any fact material to an application for the issuance of an insurance policy; or

(ii) Preparing, assisting, abetting soliciting or conspiring with another to prepare or make a statement that is intended to be presented to or by any insurer in connection with, or in support of, any application for the issuance of an insurance policy, knowing that the statement contains any false information as part of, or in support of a claim for payment or other benefit pursuant to an insurance policy; or

(iii) Making, or subscribing to a false or fraudulent account, certificate, affidavit, proof of loss or other document or writing, with knowledge that the same may be presented or used in support of a claim for payment under a policy of insurance.

A person who violates this law is guilty of civil and criminal offenses punishable by fines and imprisonment.

B. *Michigan Whistleblowers' Protection Act 469 of 1980, Mich. Comp. Laws §§ 15.361-15.369*

Michigan law contains an employee protection provision for those employees who report a violation of state, local or federal law. The Michigan Whistleblowers‟ Protection Act further provides protection to employees who participate in hearings, investigations, legislative inquiries or court actions. This Act prescribes remedies and penalties.

Specifically, employers may not discharge, threaten, or otherwise discriminate against an employee regarding the employee's compensation, terms, conditions, location, or privileges of employment because the employee, or a person acting on behalf of the employee, reports or is about to report, verbally or in writing, a violation or a suspected violation of a law or regulation or rule promulgated pursuant to law of this state, a political subdivision of this state, or the United States to a public body, unless the employee knows that the report is false, or because an employee is requested by a public body to participate in an investigation, hearing, or inquiry held by that public body, or a court action.

An employer who violates this employee protection provision may be liable to the affected employee for reinstatement, payment of back wages, full restoration of fringe benefits and seniority rights, actual damages, or any combination of remedies. Courts may also award the complainant all or a portion of the costs of litigation, including reasonable attorneys' fees and witness fees.

Each year, all team members must participate in fraud, waste and abuse training, which covers these laws in greater detail.

Reporting Methods

Team members seeking guidance on compliance issues or wishing to report actual or suspected violations of the law, regulations, policies, or the Compliance Program have several options. First, team members are encouraged to discuss the situation with their Department Head/Supervisor. If team members are uncomfortable talking to their Department Head/Supervisor or do not receive a satisfactory response, a second option is to contact the Administrator/Executive Director. If team members are uncomfortable talking to their Administrator/Executive Director or do not receive a satisfactory response, a third option is to contact the Atrium Health and Senior Living Commitment Line at 1-855-600-5850 or the Atrium

Health and Senior Living Human Resources Department at 1726 N. Ballard Road, Appleton, Wisconsin 54911 or 1-920-991-9072 (telephone). Team members making written reports are to describe the circumstances as they know them and include any relevant documents relating to the suspected violations. The envelope is to be marked “For Compliance/Personal and Confidential.”

In addition, you can contact the Office of Inspector General at 855-MI-FRAUD, or send a letter to Office of Inspector General, PO Box 30062, Lansing, MI 48909.

WISCONSIN STATE SUPPLEMENT TO THE FALSE CLAIMS PREVENTION POLICY

A. *Wisconsin Medicaid Fraud Statute, s. 49.49(1) Wis. Stats.*

In pertinent part, the state Medicaid fraud statute prohibits any person from:

i. Knowingly and willfully making or causing to be made a false statement or misrepresentation of a material fact in a claim for Medicaid benefits or payments; or

ii. Knowingly and willfully making or causing to be made a false statement or misrepresentation of a material fact for use in determining rights to Medicaid benefits or payments; or

iii. Having knowledge of an act affecting the initial or continued right to Medicaid benefits or payments or the initial, or continued right to Medicaid benefits or payments of any other individual on whose behalf someone has applied for or is receiving the benefits or payments, concealing or failing to disclose such event with an intent to fraudulently secure Medicaid benefits or payments whether in a greater amount or quantity than is due or when no benefit or payment is authorized; or

iv. Making a claim for Medicaid benefits or payments for the use or benefit of another, and after receiving the benefit or payment, knowingly and willfully converting it or any part of it to a use other than for the use and benefit of the intended person.

Anyone found guilty of the above may be imprisoned for up to six years, and fined not more than $25,000 plus three times the amount of actual damages.

B. *Wisconsin Insurance Fraud Statute, s. 943.395 Wis. Stats.*

In pertinent part, the state insurance fraud statute prohibits any person from knowingly:

i. Presenting or causing to be presented a false or fraudulent claim, or any proof in support of such claim, to be paid under any contract or certificate of insurance; or

ii. Preparing, making, or subscribing to a false or fraudulent account, certificate, affidavit, proof of loss or other document or writing, with knowledge that the same may be presented or used in support of a claim for payment under a policy of insurance; or

iii. Presenting or causing to be presented a false or fraudulent claim or benefit application, or any false or fraudulent proof in support of such a claim or benefit application, or false or fraudulent information which would affect a future claim or benefit application, to be paid under any employee benefit program.

A person who violates this law is guilty of a criminal offense punishable by fines and imprisonment.

C. *Wisconsin Health Care Whistleblower Protections, s. 146.997 Wis. Stats.*

Wisconsin law also contains an employee protection provision that prohibits health care facilities and health care providers from taking any disciplinary or retaliatory action against any employee because such employee, in good faith, reports information to an officer, director, or supervisor or a state agency regarding any activity, policy or practice of the employer that the employee reasonably believes is in violation of any federal or state law, rule, or regulation. An employer who violates this employee protection provision may be liable to the affected employee for reinstatement, restoration of benefits, back pay and costs and attorney‟s fees. Employer may also be subject to civil penalties of up to $10,000 for violations of this law.

Each year, all team members must participate in fraud, waste and abuse training, which covers these laws in greater detail.

Reporting Methods

Team members seeking guidance on compliance issues or wishing to report actual or suspected violations of the law, regulations, policies, or the Compliance Program have several options. First, team members are encouraged to discuss the situation with their Department Head/Supervisor. If team members are uncomfortable talking to their Department Head/Supervisor or do not receive a satisfactory response, a second option is to contact the Administrator/Executive Director. If team members are uncomfortable talking to their Administrator/Executive Director or do not receive a satisfactory response, a third option is to contact the Atrium Health and Senior Living Commitment Line at 1-855-600-5850 or the Atrium Health and Senior Living Human Resources Department at 1726 N. Ballard Road, Appleton, Wisconsin 54911 or 1-920-991-9072 (telephone). Team members making written reports are to describe the circumstances as they know them and include any relevant documents relating to the suspected violations. The envelope is to be marked “For Compliance/Personal and Confidential.”

Additionally, you can contact the Wisconsin Office of the Inspector General through its fraud hotline at 1-877-865-3432.