August 2020

New False Claims Act and Whistleblower Protection Policy

Dear Providers:

CountyCare is pleased to inform you that Cook County Health (CCH) has developed a new policy around compliance with the False Claims Act. This policy is being implemented due to a new requirement in our Managed Care Community Network contract with the State of Illinois Department of Healthcare and Family Services, which requires us to establish and provide written policies and procedures with detailed information about applicable federal and state False Claims Act laws and whistleblower protections to all employees, subcontractors, network providers and agents.

We all have an affirmative obligation to participate in efforts to prevent, detect, and mitigate fraud, waste and abuse in the health care system. The contract between you and CountyCare specifies that our relationship will be governed by federal and state laws, which may be amended from time to time. All network providers are therefore required to review and comply with the new policy.

If you or your organization have questions about the new policy, please contact one of the following:

CCH Chief Compliance and Privacy Officer
Office: (312) 864-0903
Email: cbodnar@cookcountyhhs.org

CCH Office of Corporate Compliance:
Office: (312) 864-7336
Email: countycarecompliance@cookcountyhhs.org

Thank you for your continued partnership.

COOK COUNTY HEALTH	Category: **CCH SYSTEM WIDE**	
Subject: **Corporate Compliance**	Page **1 of 8**	Policy #: **CC.008.01**
Title: **False Claims Act and Whistleblower Protections**	Approval Date: **July 9, 2020**	Posting Date: **July 13, 2020**

PURPOSE

This policy provides guidance for Cook County Health (CCH) workforce members, subcontractors, agents and CountyCare network providers about the federal and state False Claims Acts, including detailed information regarding the administrative, civil, and criminal remedies for false claims and statements, whistleblower protections under these laws, and a description of how the laws encourage the prevention and detection of fraud, waste, abuse, mismanagement, and misconduct in federal health care programs.

The False Claims Act (FCA) is one of several federal laws that govern fraud and abuse in government health care programs. The civil FCA protects the government from being overcharged or sold substandard goods or services. It imposes civil liability on any person who knowingly submits, or causes the submission of, a false or fraudulent claim to the federal government.

The provisions under the civil FCA indicate that an individual who does the following is liable to the United States government:

- Knowingly presents, or causes to be presented, a false or fraudulent claim to the government;
- Knowingly makes or uses (or causes to be made or used) a false record or statement to obtain payment on a false or fraudulent claim;
- Conspires to commit a violation of the FCA;
- Has possession, custody, or control of property or money used (or to be used) by the government and knowingly delivers, or causes to be delivered, less than all of the money or property;
- Knowingly makes, uses, or causes to be made or used a false record or statement materials to an obligation to pay or transmit money or property to the government; or
- Knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the government.

An individual who violates the FCA is liable to the federal government for a civil penalty of not less than $5,000 and not more than $10,000, plus three times the amount of damages which the government sustains due to the act of the individual. Certain actions may result in reduced damages. In addition, the individual will be liable for the costs of a civil action brought to recover the penalty or damages. Under the criminal FCA, penalties for submitting false claims include imprisonment and criminal fines. These may apply to individuals or entities. The Department of Health and Human Services (HHS) Office of the Inspector General (OIG) may impose administrative civil monetary penalties for false or fraudulent claims. Violation of the FCA may result in permanent exclusion from government health care programs.

The Illinois False Claims Act is a state-level version of the federal False Claims Act that is comparable to the federal law.

Both the federal False Claims Act and Illinois False Claims Act contain whistleblower provisions that serve to enlist private citizens in combating fraud against governmental entities. The whistleblower provisions, sometimes called “qui tam provisions,” were crafted to provide clear procedures and appropriate incentives for private citizens to report fraudulent schemes and participate in the resulting investigations and prosecutions.

CCH takes the detection, investigation, and prosecution of fraud and abuse very seriously, and has a fraud, waste, and abuse program that complies with Illinois and federal laws. Common fraud, waste and abuse issues include, but not are not limited to the following: Unbundling of codes, up-coding, use of add-on codes without primary Current Procedural Terminology (CPT) codes, use of diagnosis and/or procedures codes that are inconsistent with the applicable member's age or gender, use of exclusion codes, excessive use of units, misuse of benefits and claims for services not rendered.

AFFECTED AREAS

This policy applies to all CCH workforce members, departments and affiliates of CCH, as well as subcontractors and agents utilized by CCH and CountyCare network providers. CCH includes John H. Stroger, Jr. Hospital of Cook County Campus (Administration Building, Stroger Hospital & Professional Building); Provident Hospital of Cook County; Correctional Health Services of Cook County; Ambulatory & Community Health Network (ACHN) and Cook County Department of Public Health, CountyCare, and other Health Plan operations.

POLICY

A. CCH, and its Covered Persons, have an affirmative obligation to participate in efforts to prevent, detect, and mitigate fraud in the health care system.

B. CCH will provide information to all Covered Persons about the federal False Claims Act, Illinois False Claims Act, the rights of employees to be protected as whistleblowers, and CCH policies and procedures for detecting and preventing fraud, waste, and abuse.

C. CCH prohibits Covered Persons from the following:
    1. Presenting a claim for payment under government health care programs with knowledge that the claim is false or fraudulent;
    2. Presenting a claim for payment under government health care programs with knowledge that the individual who received the benefit (that is the subject of the claim) is not authorized or eligible for the benefit;
    3. Making or using a record or statement to obtain payment from a government health care program with knowledge that the record or statement is false;
    4. Making or using a record or statement to conceal, avoid, or decrease an obligation to make a payment to a government health care program with knowledge that the record or statement is false; and
    5. Knowingly presenting a claim under government health care programs for a service or product that was not provided.

D. In addition to potentially being subject to civil and criminal penalties, Covered Persons who violate the laws addressed in this policy are subject to disciplinary actions, up to and including termination of employment or contracted responsibilities.

E. Covered Persons have an affirmative responsibility to report misconduct in the workplace, including actual or potential violations of law, regulation, the CCH Code of Ethics or policies and procedures, wrongdoing, ethical standards, problems and concerns. Failing to report or concealing knowledge of a potential violation may result in administrative actions, possibly including employment or contract

termination.

F. CCH encourages all Covered Persons to make an initial written report of serious and sensitive issues relating to financial reporting, fraud, waste abuse, unethical or illegal conduct to their immediate supervisor, or to the CCH Chief Compliance & Privacy Officer, or designee. The individuals that receive these reports will work with the CCH Chief Compliance & Privacy Officer, or designee, to conduct an investigation. Every effort shall be made to protect the reporter's identity to the extent permitted by applicable law, rule, or regulation.

G. Covered Persons who report compliance problems and concerns in good faith to the appropriate CCH personnel or to a designated official or public body will be protected from any form of retaliation or retribution in accordance with this policy and the federal and Illinois False Claims Act.

H. Concerns which have been substantiated through investigation shall be reported to the CCH Audit & Compliance Committee of the Board of Directors. Individuals identified as being involved with the substantiated concern shall withstand appropriate corrective action in accordance with federal, state, and local laws, and CCH policies and procedures.

I. CCH workforce members must act in accordance with the Compliance Reporting and Non-Retaliation policy. The CCH non-retaliation rules apply to whistleblowers.

J. Covered Persons should exercise due care in all written and oral statements made to government agencies and other payers.

K. Records from reports and investigations shall be maintained for a period of time in accordance with the CCH Record Retention Policy.

DEFINITIONS

Anti-Kickback Statute: Prohibits anyone from soliciting or receiving anything of value in any form or manner whatsoever (remuneration) of any kind in exchange for referring a patient or member for services for which a federal healthcare program pays or for purchasing an item or service for which a federal healthcare program pays.

Abuse: A manner of operation that results in excessive or unreasonable costs to federal or State healthcare programs, generally used in conjunction with "Fraud" and "Waste."

Covered Person(s): All CCH workforce members, subcontractors, network providers, and agents.

Good Faith: The information reported or disclosed is reasonably believed to be true and a violation has occurred or may occur.

Federal False Claims Act: The FCA, found at 31 U.S.C. §§ 3729-3733, is one of several federal laws that govern fraud and abuse in government health care programs. The civil FCA protects the government from being overcharged or sold substandard goods or services. It imposes civil liability on any person or organization who knowingly submits, or causes the submission of, a false or fraudulent claim to the federal government. Additionally, overpayments received from a Federal health care program (e.g., Medicare,

Medicaid) that are not reported and returned within 60 days of identifying the overpayment, or the date a corresponding cost report is due, are also considered false claims. Failure to timely report and return an overpayment exposes a person or entity to liability under the FCA. The FCA defines "knowing" to include not only the traditional definition, but also instances in which the person acted in deliberate ignorance of the truth or falsity of the information or in reckless disregard of the truth or falsity of the information. Under the FCA, no specific intent to defraud is required. Further, the FCA contains a qui tam or whistleblower provision that allows a private individual to file suit on behalf of the United States and entitles that whistleblower to a percentage of any fraud recoveries. Liability under the False Claims Act can be imposed on an individual or a company.

Fraud: Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program "Fraud" is generally used in conjunction with "Waste" and "Abuse."

Illinois False Claims Act: A state-level version of the federal False Claims Act, found at 740 ILCS 175/1, that is comparable to the federal law and includes a whistleblower provision.

Illinois Whistleblower Act: Found at 740 ILCS 174/1, this law states that an employer may not retaliate against an employee who discloses information in a court, an administration hearing, or before a legislative commission or committee, or in any other proceeding, where the employee has reasonable cause to believe that the information discloses a violation of a State or federal law, rule, or regulation. The law also states that an employer may not retaliate against an employee for disclosing information to a government or law enforcement agency, where the employee has reasonable cause to believe that the information discloses a violation of a State or federal law, rule, or regulation.

Retaliation: Any adverse action taken against any member of the CCH workforce because he or she reported or complained about a potential violation of the CCH Code, policies, laws, regulations, or professional standards. Any negative action that would deter a reasonable workforce member in the same situation from making a complaint qualifies as retaliation.

Retribution: Any act of punishing or taking vengeance for someone reporting a perceived violation of the CCH Code, policies, laws, regulations, or professional standards.

Waste: The overutilization or misuse of covered and non-covered services, resources, or materials that results in unnecessary costs to the healthcare system and, as a result, to government programs (i.e., Medicare and Medicaid). Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources. "Waste" is often used in conjunction with "Fraud" and "Abuse."

Whistleblower: An individual who provides the government or other authorities with information about what he or she believes to be a violation of the law or instance of wrongdoing. Whistleblowers are often employees of the organizations that they report.

Whistleblower (or Qui Tam) Provision: The provision of the False Claims Act that allows a private individual to file a lawsuit on behalf of the United States and entitles that whistleblower to a percentage of any

recoveries. Whistleblowers may be current or former employees, hospital or office staff, patients, contractors, competitors, or others.

Wrongdoing: Conduct that does not comply with federal, state, and/or local laws, the CCH Code, or CCH policies and procedures.

Workforce Members: Consistent with the HIPAA regulation, workforce members are defined to include "employees, contractors, volunteers, trainees, and other persons whose conduct, in the performance of work for a covered entity, is under the direct control of such entity, whether or not they are paid by the covered entity." Persons who do not fall in these categories, but nonetheless perform services on behalf of the covered entity, would be considered part of the workforce for the purpose of this policy.

PROCEDURE/PROCESS

A. During New Employee Orientation and annually thereafter, CCH workforce members shall receive a description of the federal and state False Claims Acts, as well as the rights of employees to be protected as whistleblowers, and CCH's policies and procedures for detecting and preventing fraud, waste, abuse, mismanagement, and misconduct.

B. CCH subcontractors, agents and CountyCare network providers will receive information about the federal and state False Claims Acts, whistleblower protections and CCH's processes procedures for detecting and preventing fraud, waste, abuse, mismanagement, and misconduct upon the initial approval of this policy and during contracting.

C. Covered Persons must refrain from knowingly presenting any false or fraudulent claim for federal (Medicare) or state program (Medicaid) payment. "False Claims" do not include innocent mistakes or mere negligence in billing. Examples of false claims may include:
    1. Billing Medicare or Medicaid for services or tests that were not performed, or for goods that were never delivered.
    2. Billing for inappropriate or unnecessary medical procedures in order to increase Medicare or Medicaid reimbursement.
    3. Unbundling, or billing services using multiple codes when a more appropriate, all-inclusive code exists.
    4. Bundling, or billing a comprehensive code, e.g., a panel of lab tests, when only a single test/service was ordered.
    5. Double billing or charging more than once for the same goods or service.
    6. Upcoding or inflating bills by assigning "upgraded" codes that inappropriately indicate higher severity of illness or a more expensive treatment than clinically indicated/documented.
    7. Billing for brand-named drugs when generic drugs are actually provided.
    8. Charging for employees who were not actually on the job, or billing for hours that were not worked in order to maximize reimbursements.
    9. Inappropriately billing physician rates for work that was actually conducted by a nurse, resident, or intern.
    10. Receiving an overpayment from the government for sale of a good or service, and then not reporting that overpayment;

11. Failing to report and return any known overpayment within sixty (60) days of identifying the overpayment or by the date a corresponding cost report is due.
12. Billing for research that was never conducted or falsifying research data that was funded by the U.S. government.
13. Prescribing a medicine or recommending a type of treatment or diagnosis regimen in order to receive kickbacks from hospitals, labs or pharmaceutical companies.
14. Billing for unlicensed or unapproved drugs.
15. Forging physician signatures when such signatures are required for reimbursement by Medicare or Medicaid.

D. Billing for services or items generated in violation of the federal Anti-Kickback Statute.
If a Covered Person has reason to believe that any Covered Person has violated applicable laws, rules, regulations, the Code, and/or CCH policies and procedures, the individual **must** report such concerns promptly and accurately to CCH management, the CCH Chief Compliance Officer, or the CCH Corporate Compliance Hot-Line.

1. Covered Persons should first report the concern to their direct supervisors. If doing so is not practicable or appropriate, Covered Persons should discuss with other support structure individuals, e.g., the individual in the next supervisory level or another member of management.
2. Covered Persons may contact the CCH Chief Compliance Officer or designee directly, via phone or email.
3. Covered Persons may also report a concern via the confidential Corporate Compliance Hot-Line at 1-866-489-4949 or the online reporting portal at www.cchhs.ethicspoint.com. The hot-line is available 24-hours a day, seven days a week, and 365 days a year. Calls to the hotline are not traced. Callers are not required to identify themselves; however, they are permitted to do so if, for example, they wish to provide further assistance at a future point in time.

E. Covered Persons who report violations are encouraged to provide as much detail as possible, including names, dates, times, places, as well as the specific conduct that may have violated the law, Code, or CCH policies. Confidentiality will be maintained to the extent practical or permitted by law.

F. Covered Persons will not be subject to discipline, retaliation, or other adverse treatment by CCH due to raising compliance concerns, questions, or suggestions in good faith, and without intent to harm or disparage another individual.

G. If CCH determines that an individual intentionally fabricated, exaggerated, or otherwise distorted a report of wrongdoing, whether to protect themselves or harm another, the individual will not be protected under this policy and may be subject to corrective action, up to and including employment or contract termination.

H. Any CCH workforce member who retaliates against another who has raised compliance concerns, questions, or suggestions in good faith will be subject to corrective action, up to and including employment or contract termination.

I. All issues reported via the confidential Corporate Compliance Hot-line or other communication channel will be investigated by appropriate parties to the appropriate extent. Reporting individuals must cooperate and communicate truthfully in connection with investigations of suspected violations.
   1. The utilization of auditing and monitoring will help to detect and prevent fraud, waste and abuse. Monitoring processes will be utilized to ensure that functions are being adequately performed and working effectively. Results of monitoring processes, including investigative findings of non-compliance, will be communicated to senior management, the CCH Corporate Compliance Committee, and the CCH Audit & Compliance Committee of the Board of Directors, as applicable.
   2. Regular, periodic auditing performed by internal and external auditors includes identifying compliance risk areas, assessing internal controls, sampling data, testing processes, validating information, and formally communicating recommendations and corrective action steps.
   3. Additional information regarding auditing and monitoring processes related to CountyCare can be found in the CountyCare Compliance Plan and the CountyCare Fraud, Waste and Abuse Plan.

J. Reasonable corrective actions will be implemented, where applicable, to correct violations and prevent recurrence of violations. Such actions may include employment or contract termination. Corrective actions will be applied in a consistent manner and in accordance with other CCH guidelines and policies.

CROSS REFERENCES

Standards of Conduct/Code of Ethics
CCH Record Retention Policy
CCH Compliance Investigations Policy
CCH Compliance Program Hot-Line Policy
Fraud, Waste, and Abuse Reporting and Non-Retaliation Policy
CountyCare Compliance Plan
CountyCare Fraud, Waste and Abuse Plan

RELEVANT REGULATORY OR OTHER REFERENCES

Anti-Kickback Statute [42 U.S.C. § 1320a-7b(b)]
Federal False Claims Act (31 U.S.C. Sec. 3729-3733)
Criminal False Claims Act (18 U.S.C. Sec. 287)
Illinois False Claims Act, previously Illinois Whistleblower Reward and Protection Act (740 ILCS 175)
Illinois Whistleblower Act (740 ILCS 174/1, et. seq.)
Social Security Act, Sec. 1902(a)(68) (42 U.S.C. 1396a)
State of Illinois Contract between the Department of Healthcare and Family Services and County of Cook, a Body Politic and Corporate, By and Through Its Cook County Health and Hospitals System for Furnishing Health Services by a County Managed Care Community Network (2018-24-201)

POLICY UPDATE SCHEDULE

This policy will be reviewed at least every three (3) years or more often as appropriate.

POLICY LEAD

Cathy Bodnar
Chief Compliance and Privacy Officer, CCH

REVIEWER(S)

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Chief Executive Officer, CountyCare

APPROVAL PARTY(IES)

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Electronically Approved

POLICY HISTORY

Written: March 2020