Deficit Reduction Act of 2005, False Claims Act, Whistleblower Protection and Similar Laws Policy Statement

Company: Advanced Health	Approved by: Michael Hale Title: Chief Compliance Officer Current Revision Date: December 2, 2024
Department: Compliance	

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1. PURPOSE

1.1. In conformance with the Deficit Reduction Act of 2005 (the "DRA"), Advanced Health requires compliance with all laws applicable to its business, including insistence on compliance with all applicable federal and state laws dealing with false claims. Advanced Health strives to prevent, detect, and eliminate fraud, waste, and abuse in all government-funded programs from which it receives payments.

2. SCOPE

2.1. Applies to all Advanced Health employees.

3. ACRONYMS AND DEFINITIONS

3.1. Unless otherwise defined, all uppercase words will be defined the same as in the CCO Contract.

3.2. All terms and acronyms are defined in the Policy Statement below.

4. POLICIES

4.1. It is Advanced Health's policy to comply with all federal and State false claims laws, and similar laws, and provide whistleblower protection to its employees.

The following explains tools available to federal and state agencies, as well as to Advanced Health, to fight fraud, waste, and abuse in the administration of federal and state health programs and the role these tools play in preventing and detecting fraud, waste and abuse in federal and state health-care programs. Specifically, the information will summarize the following:

- The Federal False Claims Act;
- The federal administrative remedies for false claims and statements;
- The federal whistleblower laws; and
- State laws regarding false claims, false statements, and whistleblower protection.

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

The Federal False Claims Act is one of the most widely used and effective laws to fight fraud. Initially passed during the Civil War to fight fraud in military purchasing, the Federal False Claims Act (the "FCA") is now a broad federal statute that prohibits fraud in any federally funded contract or program, including Medicare and Medicaid. The FCA established liability for any person who knowingly presents, or causes to be presented, a false or fraudulent claim to the U.S. government for payment.

The term "knowingly" means that the person either had actual knowledge the claim was false, deliberately acted in ignorance of the truth or falsity of the claim, or acted in reckless disregard of the claim's truth or falsity. The term "claim" includes any request or demand for money that is submitted to the U.S. government or its contractors.

False claims for health-care providers can take a variety of forms. Examples include falsifying billing records, double-billing for items or services, overcharging for items or service, billing for services never performed or items never delivered, billing for delivering less than promised, and charging for one thing while providing another.

The Federal Administrative Remedies for False Claims and Statements

The penalties for violating the FCA are severe. Violators may be subjected to a civil penalty ranging from $10,957 to $21,916 for each false claim submitted (as adjusted from time to time for inflation). In addition, the violator can be required to pay three times the amount of damages sustained by the government for each false claim, which is typically the amount the government paid for each false claim. In addition, the Office of Inspector General (the "OIG") – the agency within the Department of Health and Human Services charged with investigating fraud and abuse – may seek exclusion of a convicted health-care provider or supplier from further participation in any federal health-care program. A violator can also be held liable to the government for costs associated with any civil action that seeks to recover penalties or damages. There are also criminal consequences under federal law for intentional participation in the submission of a false claim.

Federal Whistleblower Provisions

Any person may bring an action under this law on behalf of the government (called a "qui tam relator" or "whistleblower" suit) in federal court. The case is initiated by causing a copy of the complaint and all available relevant evidence to be served on the federal government. The case will remain sealed for at least 60 days and will not be served on the defendant so the government can investigate the complaint. The government may obtain additional time for good cause. The government on its own initiative may also initiate a case under the FCA.

After the 60-day period (or any extensions) has expired, the government may pursue the matter in its own name or decline to proceed. If the government declines to proceed, the person bringing the action has the right to conduct the action on his or her own in federal court.

If the government proceeds with the case, the qui tam whistleblower bringing the action will receive between 15 and 25 percent of any proceeds, depending on the contributions of the individual to the success of the case. If the government declines to pursue the case and the whistleblower chooses to pursue the matter legally, the whistleblower will be entitled to between 25 and 30 percent of the proceeds of the case, plus reasonable expenses, attorney's fees, and costs awarded against the defendant.

Any case must be brought within 6 years of the filing of the false claim.

Antidiscrimination /Anti-retaliation

In accordance with Advanced Health's Consolidated Compliance Plan and Fraud, Waste and Abuse Policies and Procedures, and the provisions of this law, anyone initiating a complaint or reporting a violation may not be discriminated or retaliated against or harassed in any manner by his or her employer. The employee is authorized under the FCA to initiate court proceedings to be made whole for any job-related losses resulting from any such discrimination or retaliation, including reinstatement, back pay, and other appropriate compensation.

Program Fraud Civil Remedies Act

The Program Fraud Civil Remedies Act (the "PFCRA") creates administrative remedies for making false claims separate from, and in addition to, the judicial or court remedy for false claims provided by the FCA.

The PFCRA is quite similar to the FCA in many respects but is somewhat broader and more detailed, with differing penalties. It deals with submission of improper "claims" or "written statements" to a federal agency. Specifically, a person violates this act if he or she knows, or has reason to know, he or she is submitting a claim that is:

- False, fictitious, or fraudulent;
- Includes, or is supported by, a written statement that is false, fictitious, or fraudulent;
- Includes, or is supported by, a written statement that omits a material fact, or the statement is false, fictitious, or fraudulent as a result of the omission, and the person submitting the statement has a duty to include the omitted facts; or
- For payment for property or services not provided as claimed.

A violation of this prohibition carries a $5,000 civil penalty for each such wrongfully filed claim. In addition, an assessment of two times the amount of the claim may be made, unless the claim has not actually been paid.

A person also violates this act if he or she submits a written statement that he or she knows or should know:

- Asserts a material fact which is false, fictitious, or fraudulent; or
- Omits a material fact and is false, fictitious, or fraudulent as a result of the omission. In this situation, there must be a duty to include the fact and the statement submitted contains a certification of the accuracy or truthfulness of the statement. A violation of the prohibition for submitting an improper statement carries a civil penalty of up to $5,000.

Oregon Law

Oregon does not have a state FCA, but does have other laws that prohibit false statements associated with health care items or services. Under Oregon law, a person commits the crime of making a false claim for health care payment when the person: (1) knowingly makes or causes to be made a claim for health care payment that contains any false statement or false representation of a material fact in order to receive a health care payment; or (2) knowingly conceals from or fails to disclose to a health care payor the occurrence of any event or the existence of any information with the intent to obtain a health care payment to which the person is not entitled, or to obtain or retain a health care payment in an amount greater than that to which the person is or was entitled. Making a false claim for health care payment is a Class C felony punishable by

up to 5 years in prison and a fine of up to $125,000. There is a 5-year statute of limitations from time of the claim. Currently, these Oregon laws do not contain qui tam or relator provisions. Additionally, there are no provisions for a private citizen to share a percentage of any monetary recoveries.

Like federal law, Oregon law includes whistle-blower protections. Various Oregon laws prohibit public employers and private health care employers from retaliating, discriminating or harassing employees because of their good faith disclosure of information about a violation of a law or rule or a violation that poses a risk to public or patient health, safety or welfare, or their refusal to assist employers in activity that the employee reasonably believes is in violation of a law or rule such as Oregon's False Claims for Health Care Payments law. Oregon law also prohibits employers (public or private) from discriminating against any employee who in good faith reports criminal activity or who cooperates with law enforcement in an investigation or at trial. These Oregon employee protection laws provide for both administrative and civil remedies, which may include monetary awards for actual damages and punitive damages. The Oregon Hospital Anti-Retaliation Law requires any nursing staff to notify his/her employer in writing of any suspected illegal activity, policy, or practice before disclosing it to the appropriate government agency. This notice requirement does not apply to disclosures that the employee reasonably believes to be a crime or where the employee reasonably fears physical harm as a result of the disclosure or where an emergency exists.

5. PROCEDURES

5.1. For specific procedures related to the Policy Statement, refer to Advanced Health Compliance and FWA Handbook.

6. REFERENCE SOURCES

6.1. 31 U.S.C § 3729-3733

6.2. Or. Rev. Stat. §§ 165.690 to 165.698; Or. Rev. Stat. §§ 165.990; Or. Rev. Stat. Ann. § 161.605; Or. Rev. Stat § 161.625; Or. Rev. Stat. §§ 659A.199 to 659A.224; Or. Rev. Stat. § 441.057; Or. Rev. Stat. § 659A.230 to 659A.233; Or. Rev. Stat §§ 180.750 – 180.785.

7. RESPONSIBILITIES (Compliance, Monitoring, Review)

(Compliance, Monitoring, Review)

7.1. Compliance updates this Policy.

8. RELATED DOCUMENTS

8.1. Advanced Health Compliance and Fraud, Waste and Abuse Handbook

9. ATTACHMENTS

9.1. None

10. HEALTH EQUITY IMPACT ASSESSMENT TOOL (If question does not apply, answer "Does Not Apply")

(If question does not apply, answer "Does Not Apply")

10.1. Does the policy advance equity and what are the intended outcomes? How? If not, does it have the potential to ignore or worsen existing disparities or produce other unintended consequences, should this policy be enacted? If so, what mitigation should be planned?	This policy advances equity by providing whistleblower protection and ensuring compliance with laws that prevent fraud in government-funded healthcare programs, benefiting vulnerable populations who rely on these services. It promotes fairness by ensuring resources are not diverted from those in need. Mitigation strategies include providing training on whistleblower protections, offering

	compliance assistance to smaller providers, ensuring culturally competent investigations, and supporting minority-owned contractors to avoid exclusion.
10.2. Was there equitable involvement in the drafting or revision process? How have you included those impacted in the process? Who else should be involved? Who is the focus and who may be being left out?	Yes, from the related documents which include OARs that have gone through public comments.
10.3. What are the potential equity-related disparate impacts of this policy, practice, or decision? How might this policy have a disproportionate impact, negatively or positively on those historically underrepresented or excluded? How does this policy, practice or decision perpetuate or help to dismantle historical or other barriers to equity?	Employees from marginalized communities might fear retaliation or lack awareness of whistleblower protections, which could deter reporting of fraud. On the positive side, the policy provides whistleblower protections, empowering marginalized employees to report fraud without fear. It also ensures that healthcare resources are protected for underserved populations by preventing fraud. Regular trainings on whistleblowing procedures are critical in empowering people.
10.4. What accountability, infrastructure and resources are required to implement the policy?	A dedicated Compliance Officer, employee training, and regular audits. Infrastructure requirements include secure reporting mechanisms, centralized systems for compliance documentation, and data analysis tools to detect fraud. Financial resources are required for training, technology, and staff. Investment in technology, including fraud detection software, will support quick identification and resolution of issues.
10.5. What is the plan to evaluate and monitor the policy, practice, or decision to ensure equity in the short- and long-term?	Short-term and long-term, implement regular audits over a longer period (annually or biannually) to monitor compliance and detect trends.

11. APPROVALS		
11.1 – Document Owner	Name and Title: Michael Hale, JD, BSN, CHC – Chief Compliance Officer Department: Compliance	
11.2 – Approving Manager	Name and Title: Michael Hale, JD, BSN, CHC – Chief Compliance Officer Department: Compliance Signature Mike Hale _____	
11.3 – Collaborators	Name(s) and Title(s):	
11.4 – Approvals	**Policy Review Committee** **OHA Approval (if needed)**	Date Approved: 12/16/2024 Date Approved:
11.5 – Original Effective Date	**Date: July 7, 2018**	

11.6 – Review Period	**How often PnP is reviewed:** *(Annual, Biannual, Biennial)*
11.7 – Review Date(s)	**Date: 06/26/2024, 11/15/2024**
11.8 – Revision Date(s)	**Date: 8/30/2020, 9/23/2020, 12/16/2022, 10/3/2023**
11.9 – Add to Advanced Health Website	☐

Attachment A

WESTERN OREGON ADVANCED HEALTH

ANNUAL CONFLICTS OF INTEREST QUESTIONNAIRE

This Questionnaire is to be completed annually by all persons designated as *Covered Persons* in the Conflict of Interest Procedure. Capitalized terms in this Questionnaire have the meaning set forth in the Conflict of Interest Procedure.

1. NAME AND BACKGROUND INFORMATION

Name: _____

Address: _____

Telephone Number: _____

E-Mail Address: _____

Position or Relationship to Advanced Health: _____

_____

2. CONFLICT OF INTEREST INFORMATION

A. Investments. Identify each ownership interest that you, any of your Relatives, or any Member of your Household hold or held during the last five years in any organization that provided, provides, or is likely to provide goods or services to, or compete with, Advanced Health. If there are no disclosures to make, enter the word *None*.

_____

_____

_____

B. Directive or Other Services. Identify any services that you, any of your Relatives, or any Members of your Household provides or has provided during the last five years as a director, officer, employee, or Agent of any organization that provided, provides, or is likely to provide goods or services to, or compete with, Advanced Health. If there are no disclosures to make, enter the word *None.*

_____

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C. Interests in Transactions. Identify any interest that you, any of your Relatives, any Members of your Household, or an organization that you listed in your response to subsections A or B above has or had in the past five years in a transaction to which Advanced Health or any related organization was a party (e.g., any loans, sales of goods or services, or guarantees). If there are no disclosures to make, enter the word *None*.

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D. Receipt of Gifts. Identify each Gift with a value in excess of $50, Gifts during a calendar year with an aggregate value in excess of $50, and each Gift of payment of expenses for entertainment, that you, any of your Relatives, or any Member of your Household received during the past year from any individual or organization that transacted, transacts, or is likely to transact business with Advanced Health. If there are no disclosures to make, enter the word *None.*

_____

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E. Other. Identify all other circumstances affecting you, any of your Relatives, or any Members of your Household that might appear to involve an Actual Conflict of Interest or Potential Conflict of Interest, and any circumstances that could be viewed as use of information relating to Advanced Health's business for personal profit or advantage. If there are no disclosures to make, enter the word *None*.

_____

_____

_____

ACKNOWLEDGMENT AND SIGNATURE

To the best of my knowledge and belief, the above information is true and accurate. I have received a copy of Advanced Health's Conflict of Interest Policy and Procedure, which I have read and understand, and I hereby agree to comply with these documents.

Signature _____

Name Printed _____

Date _____

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PI-Deficit Reduction Act of 2005 False Claims Act Whistleblower Protection and Similar Laws Policy Statement_11152024

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