

	Regulatory Compliance Policy	No. COMP-RCC 3.01
	Title: DEFICIT REDUCTION ACT OF 2005	Page: 1 of 5
		Effective Date: 11-30-18
		Retires Policy Dated: 09-27-11
		Previous Versions Dated: 06-23-08

I. SCOPE:

This policy applies to (1) Tenet Healthcare Corporation and its wholly-owned subsidiaries and affiliates (each, an “Affiliate”); (2) any other entity or organization in which Tenet Healthcare Corporation or an Affiliate owns a direct or indirect equity interest greater than 50%; and (3) any hospital or healthcare facility in which Tenet Healthcare Corporation or an Affiliate either manages or controls the day-to-day operations of the facility (each, a “Tenet Facility”) (collectively, “Tenet”).

II. PURPOSE:

The purpose of this policy is to comply with certain requirements set forth in Sections 6031 and 6032 of the Deficit Reduction Act of 2005 (DRA) with regard to federal and state false claims laws.

III. POLICY:

All Tenet employees, including management, and any Contractors or Agents should be educated regarding the federal and state false claims statutes and the role of such laws in preventing and detecting fraud, waste and abuse in federal health care programs. For the purposes of this Policy, “Contractor or Agent” means any contractor, subcontractor, agent, or other person which or who, on behalf of the Tenet Facility, furnishes, or otherwise authorizes the furnishing of Medicaid health care items or services, performs billing or coding functions, or is involved in monitoring of health care provided by the facility.

IV. PROCEDURE:

A. Implementation

Each Tenet entity’s implementation responsibilities include, but are not limited to:

1. Adopting an entity-specific policy that addresses the DRA requirements (see Section IV.B.);
2. Ensuring that all employees, including management, and any Contractors or Agents are provided with the policy within 30 days of commencing employment or contractor status; and
3. Ensuring that the entity’s employee handbook, if one exists, includes a detailed summary of the policy.

B. Policy Contents

The DRA includes provisions that require all healthcare providers receiving at least \$5 million in annual Medicaid payments to establish written policies for all employees, contractors and agents that provide detailed information about:

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- the federal False Claims Act (31 U.S.C. 3729-3733)
- applicable state false claims laws
- administrative remedies for false claims
- any comparable state laws pertaining to penalties for false claims and statements
- whistleblower protections

The following information must be included in a DRA policy adopted by a Tenet entity:

1. False Claims Laws General Information

One of the primary purposes of any false claims laws is to combat fraud and abuse in government programs. False claims laws do this by making it possible for the government to bring civil actions to recover damages and penalties when false claims are submitted. These laws often permit qui tam suits (whistleblowers suits) as well, which are lawsuits brought by lay people, typically employees or former employees that suspect false claims have been submitted.

There is a federal False Claims Act and a various states have adopted the False Claims Laws. Under the federal False Claims Act, any person or entity that knowingly submits a false or fraudulent claim for payment of United States Government funds is liable for significant penalties and fines. The fines include a penalty of up to three times the Government's damages, civil penalties ranging from \$5,500 to \$11,000 per false claim, and the costs of the civil action against the entity that submitted the false claims. Generally, the federal False Claims Act applies to any federally funded program, with the exception of tax fraud. The False Claims Act applies, for example, to claims submitted by healthcare providers to Medicare or Medicaid.

2. Qui Tam Provision

One of the unique aspects of the federal False Claims Act is the qui tam provision, commonly referred to as the whistleblower provision. This provision allows a private person with knowledge of a false claim to bring a civil action on behalf of the United States Government ("Government"). The purpose of bringing the qui tam suit is to recover the funds paid as a result of the false claims. If the suit is ultimately successful, the whistleblower that initially brought the suit may be awarded a percentage

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of the funds recovered. Sometimes the Government decides to join the qui tam suit. In such cases, the Government assumes responsibility for all of the expenses associated with the suit and the percentage received by the whistleblower will be lower than if the Government had not joined the suit.

Regardless of whether the Government participates in the lawsuit, the court may reduce the whistleblower's share of the proceeds if the court finds that the whistleblower planned and initiated the false claims violation. Further, if the whistleblower is convicted of criminal conduct related to his role in the preparation or submission of the false claims, the whistleblower will be dismissed from the civil action without receiving any portion of the proceeds.

3. Whistleblower Protections

The federal False Claims Act also contains a provision that protects a whistleblower from retaliation by his or her employer. This applies to any employee who is discharged, demoted, suspended, threatened, harassed, or discriminated against in his or her employment as a result of the employee's lawful acts in furtherance of a false claims action. The whistleblower may bring an action in the appropriate federal district court and is entitled to reinstatement with the same seniority status, two times the amount of back pay, interest on the back pay, and compensation for any special damages as a result of the discrimination, such as litigation costs and reasonable attorney fees.

4. State False Claims Laws.

Many states have adopted false claims laws. Each Tenet entity's policy must include a summary of the state False claims laws that have been adopted by the state in which is located. Summaries of the state false claims laws for all of the states in which Tenet Facilities are located are included in Attachment A of this Policy.

5. Reporting Concerns Regarding Fraud, Abuse and False Claims

Tenet recognizes that questions, concerns or disputes sometimes arise. Tenet believes that it is in the best interest of both its employees and the organization to resolve those questions, concerns or disputes in a forum that provides the fastest and fairest method for resolving them. Tenet employees have an obligation to report concerns using the internal methods and to understand the options available should their concerns not be resolved (see Regulatory Compliance Policy COMP-RCC 4.21, Internal Reporting of Potential Compliance Issues and the Standards of Conduct). Tenet employees, Contractors and Agents are encouraged to contact the Tenet

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entity’s Compliance Officer, another member of the entity’s management, Human Resources or the Ethics Action Line (1-800-8-ETHICS; 1-800-838-4427) to report a concern, including concerns regarding potential fraud, waste, or abuse.

C. Other Tenet Resources

As noted in the Standards of Conduct, Tenet makes every attempt to present claims for payment or approval that are accurate and truthful¹. Tenet has a number of policies which speak to its commitment to comply with state and federal healthcare program requirements. These policies are available to all Tenet employees on eTenet; many also are available in the “Our Company” tab of Tenet’s external website, (www.tenethealth.com/about/ethics-compliance). The policies and the Standards of Conduct should be made available to Tenet’s Contractors and Agents upon request. Three of the policies are:

1. Regulatory Compliance Policy COMP-RCC 4.33, Compliance with Federally Funded Healthcare Claims and Cost Reports, which speaks to the Tenet requirement that every Tenet Facility shall have processes and procedures to ensure that claims and claims- or cost report-related information that will be submitted to Federally funded healthcare programs are complete, accurate, reflect reasonable and necessary services, and comply with Federal health care program requirements.
2. Regulatory Compliance Policy COMP-RCC 4.21, Internal Reporting of Potential Compliance Issues, which establishes and defines a detailed and aggressive reporting process for any potential compliance issues, including violation of laws and regulations relating to federally funded healthcare programs. Tenet expects its contractors to report any potential compliance issues to the appropriate Compliance Officer so that the issues may be investigated and resolved.
3. Human Resources Policy HR.ERW.08, No Retaliation, which emphasizes Tenet’s strong position against retaliation of any kind, and provides steps to take in response to suspected retaliation. This policy includes measures on how the leadership must embrace and promote a no retaliation culture, including periodically reviewing and discussing this policy with their staff.

D. Enforcement

All employees whose responsibilities are affected by this Policy are expected to be familiar with the basic procedures and responsibilities created by this Policy. Failure to comply with this Policy will be subject to appropriate performance management pursuant to all applicable policies and procedures, up to and including

¹ Tenet Standards of Conduct, p. 13 (rev. 11/06)

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termination. Such performance management may also include modification of compensation, including any merit or discretionary compensation awards, as allowed by applicable law.

V. REFERENCES:

- Deficit Reduction Act of 2005, Sections 6031, 6032
- False Claims Act (31 U.S.C. 3729-3733)
- Standards of Conduct
- Regulatory Compliance Policy COMP-RCC 4.33, Compliance with Federally Funded Healthcare Claims and Cost Reports
- Regulatory Compliance Policy COMP-RCC 4.21, Internal Reporting of Potential Compliance Issues
- Human Resources Policy HR.ERW.08, No Retaliation

VI. ATTACHMENTS:

- Attachment A, Compendium of State False Claims Laws

**COMPENDIUM OF STATE FALSE CLAIMS LAWS
For States With Tenet Facilities**

Alabama:

In addition to the federal FCA, some states have enacted their own false claims statutes. There is no similar civil action by relators currently authorized under Alabama law. However, under Alabama law, prosecutors may bring criminal actions against any person who knowingly makes or causes to be made or assists in the preparation of any false statement, representation or omission of a material fact in any claim or application for payment, regardless of the amount, from the Medicaid Agency with the intent to defraud or deceive. Criminal penalties can include both fines and imprisonment.

Pursuant to the Alabama Medicaid regulations, when there has been fraud or abuse against the Medicaid program, in addition to the criminal penalties discussed above, restitution of improper payments may be pursued and administrative sanctions may be imposed. Administrative sanctions include, among other things, warning letters, pre-payment claim review, suspension of Medicaid payments, suspension of Medicaid participation, and termination of Medicaid participation. The Medicaid program defines fraud for these purposes as “an intentional deception or intentional misrepresentation made by a person with the knowledge that the deception could result in some unauthorized personal benefit or unauthorized benefit to some other person. Fraud is dependent upon evidence that must substantiate misrepresentation with intent to illegally obtain services, payment, or other gains.” Examples of fraud include the following:

- billing for services or equipment that the patient did not receive;
- charging recipients for services over and above that paid for by Medicaid;
- double billing or other illegal billing practices;
- submitting false medical diplomas or licenses in order to qualify as a Medicaid provider;
- ordering tests, prescriptions or procedures the patient does not need;
- rebating or accepting a fee or a portion of a fee for a Medicaid patient referral;
- failing to repay or make arrangements for the repayment of identified overpayments; and
- physical, mental, emotional or sexual abuse of a patient.

Suspected fraud and abuse may be reported to the Alabama Medicaid Agency Program Integrity Division or to the Medicaid Fraud Control Unit of the Alabama Attorney General's Office.

Unlike the federal FCA, Alabama law does not contain qui tam or relator provisions. There is also no provision for a private citizen to share a percentage of monetary recoveries.

Alabama law does prohibit state employers from retaliating, discriminating, or harassing state governmental employees who report a violation of state law in sworn testimony or in an affidavit. Alabama law does not contain similar protections for non-governmental employees.

Furthermore, in relation, the Alabama Medical Licensure Commission may suspend, revoke, or restrict any license to practice medicine or osteopathy or place on probation or fine any licensee when the licensee files a false or fraudulent claim with the Medicaid Agency.

Arizona:

In addition to the federal FCA, some states have enacted their own false claims statutes. There is no similar civil action by relators currently authorized under Arizona law. However, Arizona law also provides for civil or criminal penalties for false claims and statements. A.R.S. §13-1802; A.R.S. §13-2002; A.R.S. §13-2310; and A.R.S. §13-2311. Arizona law also prohibits the presentation of false claims to the state Medicaid program (“Arizona Act”). A.R.S. §36-2918 (2013). The Arizona Act provides for enforcement by the director of the Arizona Health Care Cost Containment System Administration (AHCCCS) but does not provide for individual *qui tam* actions. A.R.S. § 36-2918(C)(2013). A person who presents or causes to be presented any of the following is in violation of the Arizona law prohibiting false and fraudulent Medicaid claims:

- A claim for a medical or other item or service that the person knows or has reason to know was not provided as claimed. “Reason to know” is defined as acting in deliberate ignorance of the truth or falsity of, or with reckless disregard to the truth or falsity of information. Ariz. Admin. Code § 9-22-1101(C)(7) (2013).
- A claim for a medical or other item or service that the person knows or has reason to know is false or fraudulent.
- A claim for payment that the person knows or has reason to know may not be made by the system because:
 - The person was terminated or suspended from participation in the program on the date for which the claim is being made.
 - The item or service claimed is substantially in excess of the needs of the individual or of a quality that fails to meet professionally recognized standards of health care.
 - The patient was not a member on the date for which the claim is being made.
- A claim for a physician’s service, or an item or service incidental to a physician’s service, by a person who knows or has reason to know that the individual who furnished or supervised the furnishing of the service:
 - Was not licensed as a physician.
 - Obtained the license through a misrepresentation of material fact.
 - Represented to the patient at the time the service was furnished that the physician was certified in a medical specialty by a medical specialty board if the individual was not certified.
- A request for payment that the person knows or has reason to know is in violation of an agreement between the person and the state or the administration. A.R.S. §36-2918(A) (2013).

A person who violates the Arizona Act is subject to a civil penalty not to exceed two thousand dollars for each item or service claimed and is subject to an assessment not to exceed twice the amount claimed for each item or service. A.R.S. §36-2918(B). The civil penalty shall also include the amount for conducting an investigation, audit, or inquiry. Ariz. Admin. Code §9-22-1102(B) (2013).

AHCCCS has the burden of producing and proving, by a preponderance of the evidence that a provider or non-contracting provider presented or caused to be presented each claim in violation of the Arizona Act and any aggravating circumstance listed in §9-22-1105 of the Arizona

Administrative Code. A provider or non-contracting provider has the burden of producing and proving, by a preponderance of the evidence, any mitigating circumstance that would justify reducing the amount of the penalty or assessment as listed in §R9-22-1104 of the Arizona Administrative Code. Ariz. Admin. Code §R9-22-1111 (2013).

The Arizona Act protects whistleblowers from civil liability for reporting suspicions of fraud unless that person has been charged with or is suspected of the fraud or abuse reported. A.R.S. § 36-2918.01(B)(2013). Arizona has a separate whistleblower protection statute to generally protect public employees who disclose information regarding potential violations of the law against retaliation. A.R.S. § 38-531, et.seq. (2013).

California:

California law prohibits conduct similar to that addressed under the federal FCA.

California Government Code Sections 12650-12656 (commonly known as the California False Claims Act or CFCA), prohibit any person from submitting a false or fraudulent claim totaling over \$500 to the state or local government. The CFCA also makes it illegal for any person who benefits from a false claim, and later discovers the falsity of the claim, to fail to disclose the false claim to the applicable state or local government. The CFCA does not apply to workers' compensation claims, tax claims, or claims against public entities and employees. California officials may file a lawsuit against a suspected violator of the CFCA, or alternatively, a private individual, such as an employee, may file a qui tam lawsuit on behalf of the government. California officials may choose to participate in the qui tam lawsuit or allow the individual to proceed alone on the state or local government's behalf. If the case is successful, the individual is entitled to a portion of the government's monetary recovery. Employees who assist or participate in an action under the CFCA are protected from workplace retaliation. The CFCA imposes a civil penalty of up to \$10,000 for each separate violation of the law and violators must repay the applicable state or local government an amount equal to three times the value of the false claim.

California Welfare & Institutions Code Section 14107 prohibits fraud involving funds of the state's medical assistance programs, including Medi-Cal. This statute establishes grounds for both criminal and civil actions against any person who knowingly defrauds Medi-Cal or other state medical assistance programs by submitting false claims or making false representations. Actions under this statutory provision may only be brought by state officials. Private individuals cannot file qui tam lawsuits under this provision, although the state may offer monetary rewards of up to \$1,000 to individuals who provide information leading to recovery of fraudulently-obtained funds. Penalties for a violation of this statute include imprisonment and/or a fine not exceeding three times the amount or value of the fraud.

California Insurance Code Section 1871.7 (commonly known as the California Insurance Frauds Protection Act) imposes civil penalties for violations of California Penal Code Section 550, which prohibits knowingly presenting a false claim for a health care benefit to a private insurer. Actions under this statute may be brought by the district attorney or California Insurance Commissioner. Alternately, a qui tam lawsuit may be filed on behalf of the state by a private individual or entity, such as an employee or insurer. The state or district officials may choose to participate in the qui tam lawsuit or allow the individual to proceed alone on the state's behalf. If the case is successful, the individual is entitled to a portion of the state's monetary recovery. Employees who assist or participate in an action under this statute are protected from workplace

retaliation. Penalties for a violation of this statute include a civil penalty between \$5,000 to \$10,000, plus an assessment not exceeding three times the amount of each fraudulent claim. In addition, there may be a separate criminal prosecution for the violation of California Penal Code Section 550. Penalties for violation of Penal Code Section 550 include imprisonment of up to five years and a fine of the greater of \$50,000 or double the amount of the fraud.

Florida:

The Florida False Claims Act (FFCA) is patterned after the federal FCA. In 2013, Florida amended its own act with the specific intent to conform to recent changes to the federal FCA. Thus, both statutes are in conformity and help facilitate dual prosecution and enforcement by state and federal agencies.

However, the FFCA prohibitions apply to claims paid by instrumentalities of the state which include instrumentalities of all three branches of state government and local entities with budgetary autonomy such as counties, local municipalities, school districts, water management district and Public Service Commission. The Attorney General may file a lawsuit directly, or a private individual may begin a qui tam suit on behalf of the state by notifying and providing all material evidence to the Attorney General and Chief Financial Officer and filing a sealed complaint in the Second Judicial Circuit in and for Leon County. State officials may choose to participate in the qui tam lawsuit or allow the individual to proceed alone on the state's behalf. If the case is successful, the individual is entitled to a portion of the state's monetary recovery. Employees who assist or participate in an action under the FFCA are protected from workplace retaliation.

Florida contains an additional whistleblower statute that provides a reward to a person who reports a violation of the state's Medicaid fraud laws. The Florida Medicaid Provider Fraud Laws provides criminal penalties and fines for false statements or representations, among other things, made to the Medicaid program. This statute establishes grounds for criminal actions against any person who knowingly defrauds the state Medicaid program. A violation constitutes either a first, second or third degree felony, depending upon the monetary amount of the false claim at issue, and also subjects the violator to a mandatory statutory fine. This statute is prosecuted by state officials and may not be brought by private individuals and provides the individual who furnishes original information about the fraud the lesser of 25% of the amount recovered or \$500,000.

Georgia:

Georgia false claims law prohibits conduct similar to that addressed under the federal FCA, but the Georgia prohibitions pertain to the submission of false or fraudulent claims when payment would be made specifically by the state's Medicaid program. The law allows state officials to seek criminal penalties for violations. A provider can also be liable for a civil penalty of three times the amount of any excess payment made by the state's Medicaid programs and significant monetary damages per false claim. However, if the person committing the violation meets certain requirements by reporting the violation and cooperating with any subsequent government investigation, damages will be limited to two times the amount of actual damages suffered by the state Medicaid program.

A civil false claims action may be brought by the state Attorney General or by a private person in the name of the State of Georgia to which the Attorney General may elect to intervene. The Georgia

false claims law also includes whistleblower protection against workplace retaliation for civil actions brought by or assisted by an employee under the law.

Illinois:

Illinois law prohibits conduct similar to that addressed under the federal FCA, but the Illinois prohibitions apply to the submission of false statements or fraudulent claims that would be paid specifically by state funds.

Illinois law generally prohibits a person from: (1) knowingly presenting or causing to be presented a false or fraudulent claim; (2) knowingly making, using, or causing to be made or used, any false record or statement material to a false or fraudulent claim; (3) possessing or otherwise controlling property or money used by the state and knowingly delivering less than all the property or money; (4) making or delivering to the state a receipt of property used by the state knowing that any information on the receipt is untrue; (5) knowingly purchasing or receiving as a debt any public property from an officer of the state who may not lawfully pledge such property; (6) knowingly making, using, or causing to be made or used, a false record or statement material to an obligation to pay the state; (7) knowingly concealing, avoiding, or decreasing any obligation to pay money or transmit property to the state; or (8) conspiring to do any of the above.

For purposes of Illinois law, “knowingly” means that a person has acted with actual knowledge of the truth or falsity of the information, in deliberate ignorance of the truth or falsity of the information, or in reckless disregard of the truth or falsity of the information. Proof of specific intent to defraud is not required.

A person may file a qui tam civil action individually and on behalf of the state. The state may opt to intervene or decline to proceed with the action. In the latter case, the qui tam plaintiff may proceed. If the state proceeds with the action, the state has the primary responsibility for the action and the individual may continue as a party, subject to certain limitations. Other than the state, no one may intervene or bring a related action based on the facts of a pending qui tam action.

Persons violating the Illinois false claims laws may be liable for treble damages in addition to civil penalties of not less than \$5,500 and not more than \$11,000 per violation. If a civil claim is successful, a qui tam plaintiff may be entitled to a portion of the state’s monetary recovery plus reasonable expenses and attorney fees. Employees who assist or participate in an action under Illinois law are protected from workplace retaliation.

The U.S. Department of Health and Human Services Office of Inspector General (“OIG”) issued a determination on May 22, 2013 stating that the Illinois law complies with all requirements under Section 1909 of the federal Deficit Reduction Act of 2005.

Massachusetts:

Massachusetts has several statutes prohibiting conduct similar to that addressed under the federal FCA. These include a state False Claims Act (Mass. Gen. Laws ch 12 §§5A-5O) (commonly known as the “Massachusetts Civil False Claims Act” or “MCFA”), a statute prohibiting fraud involving the state’s Medicaid program (Mass. Gen. Laws ch 118E, §§39, 40 and 42) (“Medicaid

FCA”) and a statute criminalizing fraud in connection with health care benefits (Mass. Gen. Laws ch 175H §2).

The MCFA was modeled on the federal FCA and is not limited to false claims associated with public health care programs. It prohibits a person from submission of false or fraudulent claims (or false statements that are material to a false claim) or from benefitting from a false claim if that person does not disclose within thirty (30) days upon discovery. The prohibited acts are defined broadly, and are subject to the same “knowledge” standards set forth in the federal FCA. MFCA underwent significant amendments in July 2012. These amendments expanded the MFCA to address not only false “claims” for payments, but also false or misleading statements “material” to a false claim. In addition, knowingly presenting or causing to be presented a claim that includes items or services resulting from a violation of the federal or state anti-kickback statutes now constitutes a false claim. A person who violates the Massachusetts FCA is liable for a civil penalty of not less than \$5,000 and not more than \$10,000 per violation. The MCFCA provides for treble damages, including consequential damages, that the Commonwealth or political subdivision sustains because of the act of that person. Damages may be reduced in certain cases of self-disclosure of a false claim within thirty (30) days with fully cooperation; however, they may only be reduced to double the damage amount. Prior to 2012, reduction was permitted down to the actual amount of damages. Relators may recover between 15%-25% of any funds recovered when the state intervenes, or between 25%-30% when there is no intervention. Funds to relators may be reduced below 10% of the total amount if the State can show that the information provided by the relator was already available in a public forum. In addition, a relator’s recovery may be withheld entirely if a court determines that the relator planned and initiated the violation. Prior to the 2012 amendments, if a relator “knowingly participated” in the false claim, the relator’s recovery could have been eliminated; however, as currently written, the relator must be shown to have planned and initiated the violation for recovery to be eliminated. The State may elect to pursue a claim through litigation or alternate remedies, including an administrative proceeding. Any finding of fact or conclusion of law in that proceeding would be conclusive on all parties in a civil suit.

The Medicaid FCA prohibits fraud involving the state’s Medicaid program. Under the Medicaid FCA, any person who knowingly makes a false representation or knowingly fails to disclose any material fact pertaining to an individual’s eligibility for Medicaid benefits commits a misdemeanor, punishable by fines between \$200-500 or up to one year of imprisonment. The Medicaid FCA makes it a felony to knowingly and willfully make or cause a false statement or material representation of a material fact having to do with the payment of a public health benefit. Violation of this section of the Medicaid FCA could result in fines of up to \$10,000, imprisonment of up to five years, or both fines and imprisonment. Finally, the Medicaid FCA makes it a felony for providers to knowingly and willfully charge for any Medicaid service an amount higher than publicly established rates, a violation of which could include fines of up to \$10,000, imprisonment for up to five years, or both. In each case, persons charged with violating the Medicaid FCA may also be subject to prosecution and recoupment proceedings under other statutes.

In addition to the MFCA and the Medicaid FCA, Massachusetts has a statute making it a felony to knowingly and willfully make any false statement or representation of a material fact in any claim related to health care benefits payments or eligibility for health care benefits. Penalties for violation include fines of up to \$10,000, imprisonment for up to five years, or both. A person who violates this statute may also be sued civilly for restitution.

Michigan:

Michigan has a “Medicaid False Claim Act” and a “Health Care False Claim Act.” The Medicaid False Claim Act addresses Medicaid fraud while the Health Care False Claim Act addresses fraud against other health care insurers. Both laws contain similar prohibitions against knowingly submitting false claims, making false representations, offering or accepting bribes or kickbacks, or concealing material information. Violation of either Act is a felony punishable by imprisonment of up to 4 years, fines of between \$30,000 and \$50,000, or both. The Medicaid False Claim Act allows individuals to bring *qui tam* actions in the name of the state seeking treble damages and civil penalties for each false claim. If the Michigan Attorney General joins in the *qui tam* action, the relator may be awarded between 15% and 25% of any recoveries resulting from the action or any settlement of the claim. If the Attorney General declines to participate and the individual pursues the action independently, the award may rise to between 25% and 30%. However, if the court finds the claim was frivolous, it can require such individuals to pay the defendant’s legal costs as well as a civil fine of up to \$10,000. The Health Care False Claim Act, on the other hand, does not allow individuals to bring *qui tam* actions but does provide immunity to individuals who provide information or cooperate with an investigation of health care fraud. Any person who violates the Health Care False Claim Act must repay the health insurer the full amount of the benefits or payments made.

Missouri:

Missouri's fraud and abuse laws prohibit conduct similar to that addressed under the federal FCA and Anti-kickback Statute but the Missouri prohibitions apply to the submission of false or fraudulent claims when payment would be made specifically through a Missouri state funded medical assistance program (“MAP”), such as Medicaid. No person shall knowingly destroy or conceal records that are considered necessary. The state Attorney General may seek criminal penalties including imprisonment and a fine in addition to repayment of the funds unlawfully obtained, and investigative and prosecution costs. The state Attorney General may also bring a civil action against any person who receives a healthcare payment under a MAP as a result of a false statement, representation or concealment. Recovery may include civil penalties, plus up to three times the amount of the inappropriately received funds and costs. Only the state Attorney General can bring such actions; private individuals cannot file *qui tam* lawsuits under these provisions. Any person who discovers a violation by himself or herself or such person's organization and who reports such information voluntarily before such information is public or known to the attorney general shall not be prosecuted for a criminal violation. Missouri fraud and abuse laws include whistleblower protections against workplace retaliation and allow for original source whistleblowers to share in the recovery unless the whistleblower participated in the act constituting the violation.

New Mexico:

New Mexico law generally prohibits conduct similar to that addressed under the federal FCA, but the New Mexico prohibitions apply to the submission of false statements or fraudulent claims that would be paid specifically by state funds. New Mexico law generally prohibits a person from knowingly delivering less property or money owed to the state than indicated on a receipt or otherwise delivering a receipt falsely representing material characteristics of the related property. New Mexico law generally prohibits persons having discovered the falsity of a claim from failing to disclose the false claim to the state within a reasonable time after that discovery. Further, New Mexico law prohibits a person from knowingly submitting false statements or

misrepresentations of material fact in order to certify facilities under the Medicaid program. Notably, New Mexico law prohibits an individual from knowingly presenting, or causing to be presented, to an employee, officer or agent of the state or to a contractor, grantee or other recipient of state funds a false or fraudulent claim for payment or approval.

The U.S. Department of Health and Human Services Office of Inspector General (“OIG”) issued guidance stating that New Mexico law fails to comply with certain requirements under the federal DRA. Specifically, that guidance indicates that New Mexico law does not provide an “original source” exception provided by federal law, and thus it is not at least as effective in facilitating and rewarding qui tam actions as the federal FCA. Further, recent amendments to the federal FCA removed the requirement that claims be presented to an officer or employee of the government. Although OIG has not opined on this aspect of the New Mexico law, it is also likely that this provision is not in compliance with DRA requirements for state false claims statutes.

For purposes of New Mexico law, “knowingly” means that a person has acted with actual knowledge of the truth or falsity of the information, in deliberate ignorance of the truth or falsity of the information, or in reckless disregard of the truth or falsity of the information. Proof of specific intent to defraud is not required.

A person may file a qui tam civil action individually and on behalf of the state. The state may opt to intervene or decline to proceed with the action. In the latter case, the qui tam plaintiff may proceed. If the state proceeds with the action, the state has the primary responsibility for the action and the individual may continue as a party, subject to certain limitations. Other than the state, no one may intervene or bring a related action based on the facts of a pending qui tam action.

Persons violating the New Mexico false claims laws may be liable for treble damages, civil penalties and costs of actions brought to recover damages, including attorney fees. If a civil claim is successful, a qui tam plaintiff may be entitled to a portion of the state’s monetary recovery plus reasonable expenses and attorney fees. Employees who assist or participate in an action under New Mexico law are protected from workplace retaliation.

New Mexico Fraud Against Taxpayers Act civil actions may not be brought against conduct occurring prior to July 1, 1987. Actions under the Medicaid False Claims Act must be brought within four years. Unless the state determines otherwise, qui tam actions may not be based on allegations or transactions that are the subject of a criminal, civil or administrative proceedings in which the state is already a party.

New Mexico state law allows officials to seek criminal penalties against any person who knowingly makes a misrepresentation of material fact under the Medicaid program or against any person who knowingly submits false or incomplete information for the purpose of receiving Medicaid benefits. Private individuals cannot file qui tam lawsuits under these provisions; criminal actions may only be brought by New Mexico state officials. Criminal actions under the New Mexico Medicaid Fraud Act must be brought within five years from the date the action accrues.

North Carolina:

Pursuant to both the Medical Assistance Provider False Claims Act (N.C. Gen. Stat. §§108A-70.10, *et. seq.*) and the False Claims Act (N.C. Gen. Stat. §§1-605, *et. seq.*), North Carolina law prohibits conduct similar to that addressed under the federal FCA. However, North Carolina prohibitions apply to the submission of false or fraudulent claims that would be paid from either or both the state's medical assistance programs specifically or the State generally.

Under the Medical Assistance Provider False Claims Act, only the state Attorney General may file a lawsuit; a private individual may not file a lawsuit under that Act (otherwise known as a *qui tam* complaint) on behalf of the state. However, under the North Carolina False Claims Act, the Attorney General may file a suit on behalf of the state, and just like the federal FCA so may a private individual with actual knowledge of the alleged false claim(s). When a private individual brings a claim under the North Carolina False Claims Act that claim is brought in the name of the state of North Carolina and the individual is referred to as a *qui tam* plaintiff.

A provider who is found to have violated either Act may be liable for civil monetary penalties up to \$11,000 per false claim, plus three times the damages sustained by the State or the Medical Assistance Program. Under either Act, a provider can also be held liable for the costs of a civil action brought to recover any such penalties and damages and can be excluded from participation in both state and federal health care programs.

Individuals who act lawfully in the support of a claim brought against a provider under either Act or who bring an action under the *qui tam* provisions of the North Carolina False Claims Act are protected from workplace retaliation (for example, discharge, suspension, demotion, harassment, etc.) and the individual may pursue an action against the provider for any such retaliation.

The North Carolina Medical Assistance Provider Fraud statute (N.C. Gen. Stat. §108A-63) allows North Carolina officials to seek criminal penalties against providers who defraud the state Medicaid program by submitting false claims or making false representations. The statute also makes it unlawful for a provider of medical assistance to conceal or fail to disclose any fact or event affecting its entitlement to payment or the amount of payment due.

North Carolina may have laws which are triggered by the submission of a false or fraudulent claim to a third party payor including insurance fraud (see, for example, N. C. Gen. Stat. §58-2-161), mail fraud, and wire fraud.

Pennsylvania:

Pennsylvania law prohibits the knowing submission of false or fraudulent claims for payment of funds by or receipt of benefits from the state's medical assistance programs. More specifically, it prohibits the knowing presentation of a false claim, the knowing presentation of a claim for medically unnecessary services, the knowing submission of false information to obtain an excessive payment, and the knowing submission of false information to obtain authorization or certification to provide such services or merchandise under the state's medical assistance programs. Pennsylvania law also prohibits an individual from knowingly making a false statement, failing to disclose a material fact, or concealing an event regarding such person's eligibility for medical assistance benefits. State officials may seek criminal penalties for violations of these laws. In addition, upon conviction, the trial court must order repayment of the excessive payments or improperly obtained benefits. A provider convicted of submitting false claims must also pay an amount of up to three times the amount of excessive payments and is ineligible to participate in

the state's medical assistance program for five years. A person improperly obtaining benefits is subject to termination or restriction of the individual's medical assistance benefits and a \$1,000 penalty for each violation. Only state officials can bring such actions; private individuals cannot file *qui tam* lawsuits under these provisions. Pennsylvania false claims laws do not include whistleblower protection against workplace retaliation; however a state whistleblower law generally prohibits an employer from discharging, threatening, or otherwise discriminating or retaliating against an employee who makes a good faith report about an instance of wrongdoing or waste, or an employee who participates in an investigation, hearing, or inquiry. The remedies/penalties for violating the whistleblower law may include: civil action for injunctive relief and/or damages; reinstatement of the employee; payment of back wages; full reinstatement of fringe benefits and seniority rights; actual damages; and payment of the whistleblower's attorney fees and witness fees.

South Carolina:

South Carolina false claims law (S.C. Code Ann. §43-7-60) prohibits conduct similar to that addressed under the federal FCA, but the South Carolina prohibitions apply to the submission of false or fraudulent claims when payment would be made specifically by the state's Medicaid program. The law allows the South Carolina Attorney General to seek criminal penalties and to bring a civil action seeking triple recovery of the fraudulently received funds, as well as two thousand dollars for each false claim. Only the state Attorney General can bring such actions; private individuals cannot file *qui tam* lawsuits under these provisions. South Carolina false claims law does not include whistleblower protection against workplace retaliation.

The South Carolina Presenting False Claims for Payment statute (S.C. Code Ann. §38-55-170) provides for criminal penalties and fines if a person knowingly causes, assists, solicits, or conspires to present a false claim for payment to an insurer, a health maintenance organization, or to any person or the State of South Carolina providing benefits for health care in South Carolina. The South Carolina Medicaid False Application Statute (S.C. Code Ann. §43-7-70), Computer Crime Act (S.C. Code Ann. §16-16-10 et seq.), Insurance Fraud and Reporting Immunity Act (S.C. Code Ann. 38-55-510 et. seq.), and the South Carolina Department of Health and Human Services Administrative Sanctions Against Medicaid Providers Regulations (S.C. Code Reg. 126-400 et. seq.) also provide criminal, civil, and administrative penalties and sanctions for providers and other individuals who make false statements, submit false claims, and engage in other abusive or fraudulent acts related to health care billing and reimbursement.

Tennessee:

Tennessee has a state False Claims Act (Tenn. Code Ann. §§ 4-18-101, *et. seq.*), (the "Tennessee FCA") and a Medicaid False Claims Act (Tenn. Code Ann. §§ 71-5-181, *et. seq.*) (the "Medicaid FCA"). Both laws prohibit conduct similar to that addressed under the federal FCA. The Medicaid FCA, however, prohibits the submission of false or fraudulent claims that would be paid specifically from state Medicaid funds, including under the TennCare program. The Tennessee FCA prohibits the submission of false or fraudulent claims that would be paid from state funds except to the extent such conduct is already prohibited under the Medicaid FCA. The Tennessee FCA differs from the Medicaid FCA in that under the Tennessee FCA, a person may be liable if the person (a) is a beneficiary of an inadvertent submission of a false claim to the state, (b) subsequently discovers that the claim is false, and (c) fails to disclose the false claim to the state within a reasonable time after discovery of the false claim. The Tennessee FCA also does not apply

to any claim less than \$500 in value, nor to any claims, records or statements made pursuant to workers' compensation claims or under any statute applicable to any tax administered by the Tennessee Department of Revenue. Both laws allow state officials to file a lawsuit, or a private individual, such as an employee, to file a qui tam/whistleblower lawsuit on behalf of the state. State officials may choose to participate in the qui tam/whistleblower lawsuit or allow the individual to proceed alone on the state's behalf. If the case is successful, the individual is entitled to a portion of the state's monetary recovery. Employees who assist state officials or participate in an action under either the Tennessee FCA or the Medicaid FCA, or who are otherwise "acting in furtherance of an action" or "other efforts to stop" conduct prohibited by the acts are protected from workplace retaliation. Relief for employees who are impermissibly retaliated against includes reinstatement with the same seniority status, up to two times the amount of back pay (plus interest) and compensation for any special damages sustained including litigation costs and attorneys' fees. Relief under the Tennessee FCA may also include punitive damages where appropriate. Tennessee has also adopted several other false claims statutes that are intended to prevent fraud and abuse in the TennCare program (Tenn. Code Ann. Sec. 71-5-2501, *et. seq.* (the "TennCare Fraud and Abuse Reform Act"); Tenn. Code Ann. Sec. 71-5-2601, *et. seq.* ("Prevention of Fraud and Abuse in TennCare")). These laws generally prohibit the filing of any false or fraudulent claim or documentation in order to receive compensation from the TennCare program. These laws also allow state officials to seek criminal penalties against any person who knowingly defrauds the state Medicaid/TennCare program by submitting false claims or making false representations. Private individuals cannot file qui tam/whistleblower lawsuits under the provisions of these laws; criminal actions may only be brought by state officials. However, under the TennCare Fraud and Abuse Reform Act, the Tennessee Office of Inspector General is authorized to pay a monetary reward for information that leads to the arrest and conviction of any person or entity that has engaged in TennCare fraud.

Texas:

Texas law prohibits conduct similar to that addressed under the federal FCA, but the Texas prohibitions apply to the submission of false or fraudulent claims or statements that would be paid specifically by the state's medical assistance program or would qualify a provider to receive payment thereunder. Further, Texas law prohibits a person from knowingly submitting false statements or misrepresentations of material fact in order to certify facilities under the Medicaid program or conspiring to engage in conduct that constitutes a violation of the Texas Medicaid Fraud Prevention Act ("TMFPA"). A private individual, such as an employee, may file a qui tam lawsuit on behalf of the state government; although, a person may not file a qui tam lawsuit based on public information unless the person bringing that action is an original source of the information. An "original source" means an individual who, prior to a public disclosure, has voluntarily disclosed to the state the information on which allegations or transaction in a claim are based, or has knowledge that is independent of and materially adds to the publicly disclosed allegation or transactions and who has voluntarily provided the information to the state before filing an action. A person may recover for an unlawful act for a period of up to six years before the date the lawsuit was filed, or for a period beginning when the unlawful act occurred until up to three years from the date the state knows or reasonably should have known facts material to the unlawful act, whichever of these two periods is longer, regardless of whether the unlawful act occurred more than six years before the date the lawsuit was filed. However, a person may not recover for an unlawful act that occurred more than 10 years before the date the lawsuit was filed.

A person who is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment in connection with the person's initiation of, testimony for, or assistance in a qui tam lawsuit must bring suit on an action not later than the third anniversary of the date on which the cause of action accrues. The cause of action accrues on the date the retaliation occurs.

The state officials may choose to participate in the qui tam lawsuit or allow the individual to proceed alone on the state's behalf. If the state proceeds with the action, the state has the primary responsibility for the action and the individual may continue as a party, subject to certain limitations. Other than the state, no one may intervene or bring a related action based on the facts of a pending qui tam action.

If the case is successful, the individual is entitled to up to ten percent (10%) of the state's monetary recovery plus reasonable expenses, reasonable attorney's fees, and costs that the court finds to have been necessarily incurred. Employees, contractors, and agents who assist or participate in an action under Texas' False Claims law are protected from workplace retaliation. To prevail in a civil or administrative proceeding, proof of specific intent to knowingly file or submit a false claim is not required. Additional state law allows state officials to seek criminal penalties against any person who knowingly defrauds the state Medicaid program by submitting false claims or making false representations. Private individuals cannot file qui tam lawsuits under these provisions; criminal actions may only be brought state officials.

Texas Medicaid guidance requires that entities receiving annual Medicaid payments of at least \$5,000,000 to establish written policies addressing employee roles in preventing and detecting waste, fraud, and abuse. These written policies must address Texas civil and criminal laws relating to false claims. In addition, policies and procedures must address employee whistleblower protections.

Arkansas:

(applicable to Saint Francis Hospital)

Arkansas law contains two statutes prohibiting conduct similar to that addressed under the federal FCA. The Arkansas Medicaid Fraud False Claims Act, Ark. Stat. Ann. §§ 20-77-901 through 20-77-911 ("AMFFCA") is a civil statute that prohibits someone from knowingly making false statements or concealing knowledge related to any benefit or payment under the state Medicaid program, knowingly converting a benefit to a use not intended, knowingly soliciting or inducing remuneration in exchange for referrals, knowing charging in excess of established rates, and knowingly participating in the Medicaid program after having been being found guilty (or pled guilty or no contest) of a Medicaid fraud charge or violation of other Medicaid statutes. Like the federal FCA, penalties for violation include a fine of \$5,000-\$10,000 per claim and treble damages may be imposed.

In addition, the Arkansas Medicaid Fraud Act, Ark. Stat. Ann. §§ 5-55-101 through 5-55-113 ("AMFA") is a criminal statute that makes criminal those actions under the AMFFCA; however, it requires a more stringent showing of intent, as it uses a "purposely" standard rather than a "knowingly" standard. A violation constitutes either a Class A misdemeanor, a Class B felony or a Class C felony, depending upon the monetary amount of the false claim at issue, and also subjects the violator to a mandatory statutory fine.

Unlike the federal FCA, private individuals cannot file qui tam lawsuits under either law, even if the individual has original information concerning fraud. Both statutes do permit individuals who report fraud to receive up to 10% of the total amount recovered.

Delaware:

(applicable to Hahnemann University Hospital and St. Christopher's Hospital for Children)

Delaware false claims law prohibits conduct similar to that addressed under the federal FCA.

The law allows the court to assess three times the amount of excess payment by the state's Medicaid programs. However, if the person committing the violations meets certain requirements by reporting the violation and cooperating with any subsequent government investigation, the court may assess not less than two times the amount of the excess payment.

A civil false claims action may be brought by the state Attorney General or by a private citizen in the name of the State of Delaware. A whistleblower may be able to share in a portion of proceeds of the recovery. Delaware law contains whistleblower protections against workplace retaliation.

Indiana:

(applicable to the following Illinois hospitals: MacNeal Hospital, Berwyn; Weiss Memorial, Chicago; West Suburban Medical Center, Oak Park; Westlake Hospital, Melrose Park)

Indiana law generally prohibits the same activities prohibited by the federal FCA, including the knowing submission to the state of false or fraudulent claims for payment or approval or making or using a false statement to receive payment or approval. In addition, Indiana law prohibits someone from knowingly or willingly causing someone else to violate the Indiana false claims act. See Indiana Code § 5-11-5.5-1 and Indiana Code § 5-11-5.5-2 ("Indiana FCA")

Unlike the federal FCA, Indiana FCA does not contain a maximum penalty, stating that the penalty for violation shall be at least \$5,000 per violation and up to three times the damages the state sustained. Such penalty is subject to reduction to no less than twice the damages sustained in certain cases, such as voluntary disclosure with full cooperation.

Indiana FCA generally is consistent with the federal FCA regarding statute of limitations, whistleblower protections and relator's recovery. Of note, however, is that while the federal FCA provides for a reduction in the relator's proceeds if the relator planned and initiated the violation, Indiana FCA prohibits such a relator from sharing in any recovery.

In addition to the Indiana FCA, Indiana Code § 35-43-5-7.1 ("Indiana Medicaid Act") also prohibits a person from knowingly or intentionally filing a false or fraudulent claim to the Indiana Medicaid program, from otherwise obtaining payment from the Medicaid program by false or misleading statements, from concealing information from the Medicaid number, or from acquiring a provider number under false pretenses. Violation is a Class D felony, and becomes a Class C felony if the value of the offense is at least \$100,000.

Mississippi:

(applicable to Saint Francis Hospital)

The State of Mississippi has not adopted any false claims acts or statutes that contain qui tam or whistleblower provisions that are similar to those found in the federal False Claims Act. Mississippi law does broadly prohibit individuals or entities from intentionally obtaining anything of value by means of a false claim in connection with the delivery of or payment for any insurance claim. See Miss. Code Ann. § 7-5-303. The Insurance Integrity Enforcement Bureau is responsible for enforcement of this prohibition, and various individuals and entities, including health care providers or anyone with a belief that a false claim was submitted, may report this information to the Bureau. The Bureau has sole discretion to determine whether or not to pursue prosecution of the potential violation. Furthermore, there are no whistleblower protections for informants who report to the Bureau, and no provisions permitting the government to split monetary recoveries with informants whose information leads to claims that are ultimately successfully.

Mississippi has also adopted a generally applicable Medicaid Fraud Control Act that makes it unlawful for a person to submit false and fraudulent claims to the Mississippi Medicaid program. See Miss. Code Ann. 43-13-201. Violations of the Act are both civil and criminal offenses and are punishable by imprisonment and significant monetary penalties.

New Jersey:

(applicable to Hahnemann University Hospital and St. Christopher's Hospital for Children)

New Jersey has a False Claims Act that prohibits conduct similar to that addressed under the federal FCA. The False Claims Act prohibits the submission of false or fraudulent claims to any State agency. Either a private person (as a qui tam plaintiff) or the Attorney General may bring an action for a violation of the Act. The Attorney General may elect to intervene in or, in some cases, take over a private individual's qui tam action. If the Attorney General intervenes and prevails in an action brought by a person under the Act, the qui tam plaintiff may be entitled to receive a portion of the proceeds of the action. The Act also affords protection from retaliation for people who file qui tam lawsuits pursuant to the Act. It states that any employee who is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment because of lawful action taken in furtherance of a qui tam action is entitled to recover damages. He or she is entitled to "all relief necessary to make the employee whole," including reinstatement with the same seniority status, twice the amount of back pay (plus interest), and compensation for any other damages the employee suffered as a result of the discrimination. The employee also can be awarded litigation costs and reasonable attorneys' fees.

New Jersey also enacted the Medical Assistance and Health Services Act, which specifically addresses fraud in the context of its Medicaid program. Liability may attach for knowingly and willfully submitting a false claim to the Medical Assistance program, for making false statements in order to obtain Medicaid benefits or payments, or for concealing or failing to disclose information that would affect a person's continued right to receive benefits or payments, among other things. Violations of the Act can lead to civil money penalties and criminal penalties. There are no qui tam provisions relating to this Act.