# UNIVERSITY POLICY

**Section:** 100.2.8

**Section Title:** Clinical, Compliance, Ethics & Corporate Integrity: Healthcare Compliance Policies

**Policy Name:** Fraud, Waste and Abuse Protection and the Federal Deficit Reduction Act of 2005

**Formerly Book:** 00-01-15-55:05

**Approval Authority:** RBHS Chancellor

**Responsible Executive:** Chief University Compliance Officer

**Responsible Office:** University Ethics & Compliance

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**Contact:** University Ethics & Compliance, ethics@uec.rutgers.edu

## 1. Policy Statement

This policy provides guidance to Rutgers Biomedical and Health Sciences (“RBHS”) and other Rutgers University schools, units, and departments that bill federal or state programs for healthcare-related goods or services (the “Related Healthcare Entities”) and independent contractors who may be engaged by the Related Healthcare Entities as to the requirements of the Federal Deficit Reduction Act of 2005 (“DRA”) and fraud, waste, and abuse protections contained in various state and federal laws and regulations.

## 2. Reason for Policy

The provisions of this policy are intended to satisfy the requirements of the DRA, particularly Section 6032, by providing information about federal and state laws relating to liability for false claims and statements.

## 3. Who Should Read This Policy

This policy applies to and should be read by all employees, contractors, and agents of the Related Healthcare Entities as to the requirements of the DRA and fraud, waste and abuse protections provided by state and federal laws and regulations. Employees of other University departments that support the Related Healthcare Entities in their operations, including but not limited to University Procurement Services, The Office of the Senior Vice President and General Counsel, University Human Resources, University Institutional Planning and Operations, and other components of University Finance & Administration also should read this policy.

4. **Resources**

University Policy 100.2.2: Excluded Individuals and Entities

University Policy 100.2.10: Reporting Compliance and Ethics Concerns

5. **Definitions**

A. "Contractor" or "Independent Contractor" means any vendor, subcontractor, agent, or other person who, on behalf of the Related Healthcare Entity, furnishes, or otherwise authorizes the furnishing of Medicaid health care items or services, performs billing or coding functions, or is involved in the monitoring of health care provided by the entity.

B. "Excluded Individual" means any individual or entity who is currently excluded from participation in Federal and/or state health care programs as defined in University Policy 100.2.2.

C. "Related Healthcare Entity" or "Related Healthcare Entities" includes RBHS and all other Rutgers University schools, units, and departments that bill federal or state programs for healthcare-related goods or services.

6. **The Policy**

Section 6032 of the DRA requires any entity that receives payments of at least $5 million annually from a State Medicaid Plan to disseminate written policies to all employees, contractors, and agents of the entity that provide detailed information about the Federal False Claims Act, any state laws pertaining to civil or criminal penalties for false claims and whistleblower protections, and the role of such laws in the prevention and detection of fraud, waste, and abuse in federal health care programs.

The State of New Jersey requires that Rutgers annually certify its compliance with Section 6032. Because Rutgers itself is not a provider entity, Rutgers obtains certifications from each of the Related Healthcare Entities that are selected by the New Jersey Medicaid Program each year to complete certifications.

**Summaries of Federal and State Laws as Required by Section 6032 of the DRA:**

Following are summaries of civil and criminal statutes enacted by the Federal Government and by the State of New Jersey, which provide penalties for false or fraudulent claims and authorize broad investigative authority for federal and state authorities:

A. Federal Civil False Claims Act (31 U.S.C. §3729-3733). The Federal Civil False Claims Act ("FCCA") imposes civil liability on any person who engages in any of the following forms of misconduct:

1. False Claims. Presenting, or causing the presentment of, a false claim for payment or approval.

2. False Records of Statements. Making, using, or causing others to make or use, a false record or statement that is material to a false or fraudulent claim.

3. Conspiracy. Conspiring to violate the FCCA.

4. Conversion. Failing to return government property.

5. False Receipts. Making or delivering a receipt of government property with knowledge that the receipt contains false information.

6. Unlawful Purchase of Government Property. Buying public property from a government employee who may not lawfully sell it.

7. Reverse False Claims. Making, using, or causing to be made or used, a false record or statement material to an obligation to pay money to the government; or concealing, avoiding, or falsely decreasing an obligation to pay money to the government.

Although the FCA creates liability for seven types of conduct, most FCA cases involve allegations that the defendant knowingly submitted or caused another to submit a false or fraudulent claim for payment to the government. The term “claim” includes a request or demand for any portion of money or property provided by the federal government.

The FCA punishes only “knowing” submissions of false claims; it does not require proof that the individual had a specific intent to defraud the government. Rather, the FCA provides that the terms “knowing” and “knowingly” mean that a person:

- had actual knowledge of that the statement or claim was false; or
- acted in deliberate ignorance of whether information was true or false; or
- acted in reckless disregard of the truth or falsity of the information.

Potential civil liability includes penalties of between $12,537 and $25,076 per claim (these amounts are current as of May 9, 2022, and are regularly adjusted for inflation), treble damages, and the costs of any civil action brought to recover such penalties or damages.

A FCA violation is also grounds for suspension or exclusion from doing business with the Federal Government, and the Department of Health & Human Services Office of Inspector General may choose to exclude an individual or entity under Section 1128 of the Social Security Act for conduct prohibited under the FCA.

The Attorney General of the United States is required to investigate violations of the FCA and may file suit to enforce the FCA. Before filing suit, the Attorney General may seek the production of documents and written answers and oral testimony pursuant to an investigative demand or demands.

Private persons may also bring actions in the name of the government for violations of the FCA (called, “qui tam” lawsuits). When the action is filed it remains under seal for at least sixty days to provide the United States Government the opportunity to intervene in the lawsuit and prosecute, dismiss, or settle the action. If the Government does not intervene or otherwise lawfully dismiss the action, the private party who sued may proceed with the action.

If the government intervenes and assumes control of the lawsuit, the qui tam plaintiff may be awarded between fifteen to twenty-five percent of the proceeds of a judgment or settlement.

If the qui tam plaintiff proceeds absent government involvement in the lawsuit, the plaintiff may be awarded between twenty-five to thirty percent of the recovery. In addition, recovery of reasonable attorneys’ fees and costs may be ordered.

If the civil action is frivolous, vexatious, or brought to harass, the plaintiff may be ordered to pay the defendant’s fees and costs. If found guilty of a crime associated with the violation, the plaintiff is not entitled to any recovery.

B. Federal Health Care Fraud Statute (18 USC 1347). The federal health care fraud statute imposes criminal penalties for anyone who knowingly and willfully executes, or attempts to execute, a scheme or deception to:

- defraud any health care benefit program; or

- obtain, by means of false or fraudulent pretense, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program, in connection with the delivery of or payment for health care benefits, items, or services.

The penalty for violating the federal health care fraud statute is a criminal fine and/or imprisonment of up to ten years.

If a violation of the federal health care fraud statute results in serious bodily injury (as defined in 18 USC 1365), penalties could include a criminal fine and/or imprisonment of up to 20 years.

If a violation of the federal health care fraud statute results in death, penalties could include a criminal fine and/or imprisonment of up to life in prison.

C. Federal Program Fraud Civil Remedies Act of 1986 (38 U.S.C. §3801-3812). The Program Fraud Civil Remedies Act ("PFCRA") gives federal agencies the ability to initiate administrative proceedings on claims of $150,000 or less, when the United States Department of Justice ("DOJ") elects not to pursue False Claims Act remedies for the claim. The PFCRA provides an administrative remedy promulgated to complement the FCA. PFCRA cases typically involve smaller claims and false statements the DOJ might otherwise not select for criminal or civil enforcement. The PFCRA's liability provisions are similar to the FCA liability provisions, except PFRCA extends to false statements even in the absence of any claim.

PFCRA liability arises when a person makes, presents, or submits (or causes to be made, presented, or submitted) to the Government, false, fictitious, or fraudulent claims or statements that the person knew (or had reason to know) were false.

The term "claim" includes any request or demand for any payment, property, services, or benefits provided by the federal government. Examples include invoices, progress payment requests, and submissions related to grants.

The term "knows or has reason to know" includes actual knowledge as well as acts in deliberate ignorance, or reckless disregard, of the truth or falsity of the information. No proof of specific intent to defraud is required.

A false statement is a representation, certification, affirmation document, or other submission that is accompanied by an express certification of truthfulness or accuracy, made with respect to a claim or with respect to eligibility for contracts, grants, loans, or other benefits.

Federal agencies may administratively pursue these "small" false claims and certified false statements within six years of the claim being made. A person may be penalized $5,000 per claim or statement and may be assessed up to double the amount falsely claimed.

D. The New Jersey Medical Assistance and Health Services Act (NJSA 30:4D-17(a)-(d)). The criminal provision of the New Jersey Medical Assistance and Health Services Act ("MAHSA") provides penalties for individuals and entities engaging in fraud or other criminal violations relating to programs funded by Title XIX of the Social Security Act. MAHSA allows the imposition of penalties at the same level provided for under the

Federal False Claims Act, and imprisonment of up to three years or both, upon a recipient or a provider who is convicted for willfully receiving monies to which they were not entitled.

The civil provisions of MAHSA (NJSA 30:4D-17(e) - (i)) allow (a) interest on the amounts of excess benefits or payments made; (b) payment of up to three times the amount of excess benefits or payments received; and (c) payment of $2,000 for each excessive claim for assistance, benefits, or payments.

In addition to recovery actions, violations can result in the exclusion of an individual or entity from participation in all health care programs funded in whole or in part by the New Jersey Division of Medical Assistance Services. Recovery and exclusion can also be obtained as part of a criminal prosecution by the Medicaid Fraud Section of the New Jersey Division of Criminal Justice.

E. The New Jersey Health Care Claims Fraud Act (NJSA 2C:21-4.2 and 4.3; NJSA 2C:51-5). The New Jersey Health Care Claims Fraud Act ("NJHCCFA") is a criminal statute that prohibits any person from making, or causing to be made, a false, fictitious, fraudulent, or misleading statement of material fact in, or omitting a material fact from, or causing a material fact to be omitted from, any record, bill, claim or other document that a person submits, attempts to submit, or caused to be submitted for payment or reimbursement for health care services.

A practitioner who knowingly commits an act of healthcare claims fraud may be charged with a second degree criminal offense, which provides for a penalty of automatic permanent forfeiture of health care licenses. When a practitioner commits an act of healthcare fraud that is attributed to recklessness, the charge is a third degree criminal offense, which provides for a penalty of a one-year suspension.

Any person who violates the NJHCCFA is guilty of a criminal offense punishable by fines up to an amount equal to five times the pecuniary benefit obtained or sought by such person.

A person found guilty of violating the NJHCCFA may be imprisoned up to 10 years as well as required to pay fines up to five times the amount of the fraudulent claim.

F. The New Jersey False Claims Act (N.J.S.A. 2A 32C-1). The New Jersey False Claims Act ("NJFCA") makes it unlawful for any person to: (1) knowingly present, or cause to be presented, a false or fraudulent claim for payment or approval; (2) knowingly make, use, or cause to be made or used, a false record or statement material to a false or fraudulent claim; (3) knowingly make, use or cause to be made or used, a false record or statement material to an obligation to pay or transmit money or property to a state government entity, or knowingly conceal or knowingly and improperly avoid or decrease an obligation to pay or transmit money or property to a state government entity; or (4) conspire to commit one or more of the foregoing violations.

The New Jersey Attorney General shall investigate suspected violations of the NJFCA and may bring a civil action against a person who has violated the NJFCA. An individual may also bring a private civil action on behalf of the individual and the state. If the New Jersey Attorney General intervenes in a "qui tam" action, the private plaintiff may receive a percentage of the funds recovered. A violator of the NJFCA will be liable to the state for three times the amount of damages sustained by the state and attributable to the violator, plus a civil penalty of at least $5,000 but no more than $11,000.

G. The New Jersey Fraud Prevention Act (N.J.S.A 17:33A-1 et seq.). The statute was enacted to facilitate the detection of insurance fraud, promote the development of fraud prevention programs, require restitution of fraudulently obtained insurance

benefits, and reduce the amount of premium dollars used to pay fraudulent claims. Violations of the statute occur in numerous different ways, including by knowingly presenting or causing to be presented any false or misleading information material to the claim

**Ensuring that Rutgers Vendors Comply with Section 6032 Requirements**

To ensure that Rutgers vendors/contractors comply with DRA Section 6032, the following language appears in the Standard Terms and Conditions issued by Rutgers University Procurement Services when awarding a contract:

"The following is applicable only to those vendors that provide Medicaid health care items or services, perform billing or coding functions, or are involved in the monitoring of health care provided by the entity goods and services to the schools/units/institutes of Rutgers Biomedical and Health Sciences. Vendor represents and warrants that it maintains policies and educates those members of its workforce who are engaged in providing the services under this agreement as well as those individuals with direct supervision of the services under this agreement (collectively, "Applicable Individuals") regarding federal and New Jersey statutes designed to prevent and detect fraud, waste, and abuse in Medicaid and other federally-funded programs and related whistleblower protections, and conducts monthly background checks to identify those Applicable Individuals who are excluded, as required by Section 6032 of the Deficit Reduction Act of 2005, codified at 42 U.S.C.A. 1396a(a)(68), and places the same obligations on all of its contractors and agents."

**Whistleblower Protections**

The Federal False Claims Act includes an anti-retaliation provision protecting whistleblowers from retaliation (31 U.S.C. § 3730(h)). Rutgers prohibits retaliation and intimidation against anyone who reports a concern made in good faith. Anyone who has provided information who believes they are the subject of retaliation should immediately report in writing the facts supporting the allegation to University Ethics and Compliance. All reported concerns and claims of retaliation or intimidation will be investigated and any individual who has engaged in acts of retaliation or intimidation will be subject to appropriate disciplinary action.

The New Jersey False Claims Act (N.J.S.A. § 2A:32C-10) contains an employee protection that prohibits an employer from discharging, demoting, suspending, threatening, harassing, or otherwise discriminating against an employee for lawfully disclosing information regarding a false claims action against the employer.

Under the New Jersey Conscientious Employee Protection Act (NJSA 34:19-1 et seq.), an employee is protected from retaliation in their employment if they: (1) Disclosed, or threatened to disclose, to a supervisor or public body an activity, policy, or practice of the employer, or of another employer with whom there is a business relationship, that the employee reasonably believed to be in violation of a law, or a rule or regulation issued under the law, or fraudulent or criminal; or (2) Provided information or testimony to a public body conducting an investigation, hearing, or inquiry into any violation of law, or a rule or regulation issued under the law, by the employer or another employer, with whom there is a business relationship; or (3) Objected to or refused to participate in any activity, policy, or practice which the employee reasonably believed: (a) is in violation of a law, or a rule or regulation issued under the law; (b) is fraudulent or criminal; or (c) is incompatible with a clear mandate of public policy concerning the public health, safety, and welfare or protection of the environment.

**Ways to report include all of the following:**

The University Helpline is available 24 hours a day to accept compliance concerns from the Rutgers community. Reports may be filed by calling 1-833-RU-ETHICS or at: https://helpline.rutgers.edu

The Office of Employment Equity at 1-848-932-3973 or at employmentequity@hr.rutgers.edu

**Additional reporting methods include:**

New Jersey Medicaid Fraud Division at 1-888-937-2835 or
https://www.nj.gov/comptroller/about/work/medicaid/complaint.shtml

New Jersey Insurance Fraud Prosecutor Hotline at 1-877-55-FRAUD or
https://njinsurancefraud2.org/#report

United States Department of Health and Human Services-Office of Inspector General at 1-800-HHS-TIPS or https://oig.hhs.gov/fraud/report-fraud/.