VIRTUA HEALTH FRAUD AND ABUSE PREVENTION POLICY SUMMARY

It is the policy of Virtua to obey all state and federal laws and to implement and enforce procedures to detect and prevent fraud, waste and abuse regarding payments to Virtua from federal or state healthcare programs, and to provide protections for those who suspect and report wrongdoing. Section 6032 of the Deficit Reduction Act of 2005 requires Virtua to set forth certain state and federal laws and Virtua Policies and Procedures relating to false claims and statements, and protections against reprisal or retaliation against those who report wrongdoing.

SUMMARY OF STATUTES AND REGULATIONS

Role of False Claims Laws: The laws described in this policy create a comprehensive scheme for controlling waste, fraud and abuse in federal and state health care programs by giving appropriate governmental agencies the authority to seek out, investigate and prosecute violations. Enforcement activities are pursued in three available forums -- criminal, civil and administrative. This provides a broad spectrum of remedies to battle this problem. Anti-retaliation protections for individuals who make good faith reports of waste, fraud and abuse encourage reporting and provide broader opportunities to prosecute violators. Statutory provisions, such as the anti-retaliation provisions of the Civil False Claims Act, create reasonable incentives for this purpose. Employment protections create a level of security employees need to assist with the prosecution of these cases.

Federal False Claims Act (31 U.S.C. §§ 3729 – 3733)

The Federal False Claims Act (FCA) imposes civil liability on any person or entity who, in order to receive payments from Medicare, Medicaid or other federally funded health care programs, knowingly 1) files a false or fraudulent claim; 2) uses a false record or statement to obtain payment on a false or fraudulent claim; or 3) conspires to defraud Medicare, Medicaid or other federally funded health care program. "Knowingly" means 1) actual knowledge that the information on the claim is false; 2) acting in deliberate ignorance of whether the claim is true or false; or 3) acting in reckless disregard of whether the claim is true or false. Knowingly requires no proof of specific intent to defraud.

A person or entity found liable under the Federal False Claims Act is subject to a civil monetary penalties plus damages. Anyone may bring a *qui tam* action under the Federal False Claims Act in the name of the United States in federal court. If the government proceeds with the case, the person who filed the action will receive between 15 percent and 25 percent of any recovery if he or she was not involved with the wrongdoing, If the government decides not to pursue the case, the person who filed the action has the right to continue with the case on his or her own. and if successful, is entitled to between 25 percent and 30 percent of any recovery, plus reasonable expenses and attorneys' fees and costs. Anyone initiating a *qui tam* case may not be discriminated or retaliated against in any manner by their employer.

Substantive and procedural amendments to the FCA were enacted in 2009 and 2010 in the Fraud Enforcement and Recovery Act of 2009 ("FERA"), the Patient Protection and Affordable Care Act ("PPACA"), and the Dodd-Frank Wall Street Reform and Consumer Protection Act ("Dodd-Frank"). All of these amendments will make it easier for the government and qui tam relators to conduct investigations and obtain recoveries under the FCA in the future.

Federal Program Fraud Civil Remedies Act (31 U.S.C. §§ 3801 – 3812)

The Program Fraud and Civil Remedies Act (PFCRA) creates administrative remedies for making false claims and false statements. These penalties are separate from and in addition to any liability that may be imposed under the Federal False Claims Act. PFCRA imposes liability on people or entities who file a claim that they know or have reason to know: 1) is false, fictitious, or fraudulent; includes or is supported by any written statement that contains false, fictitious, or fraudulent information; 2) includes or is supported by a written statement that omits a material fact, which causes the statement to be false, fictitious, or fraudulent, and the person or entity submitting the statement has a duty to include the omitted fact; or 3) is for payment for property or services not provided as claimed. A violation of this section of the PFCRA is punishable by a $5,500 civil penalty for each wrongfully filed claim, plus an assessment of twice the amount of any unlawful claim that has been paid.

Patient Protection and Affordable Care Act (PPACA: PL 111-148 – MARCH 2010)

The Patient Protection and Affordable Care Act (PPACA) was signed into law by President Obama on March 23, 2010. The PPACA links the retention of program overpayments to potential liability under the False Claims Act. Failure to report and repay any overpayment within the timeframe may result in a violation of the False Claims Act, civil monetary penalty, or other penalties. Unpaid overpayments are also grounds for program exclusion. Furthermore, states are required to terminate the participation of any individual or entity that has been excluded under any other State plan or Medicare. In addition, a claim that includes items or services resulting from a violation of the Anti-Kickback Statute now constitutes a false or fraudulent claim under the False Claims Act.

New Jersey False Claims Act, P.L. 2007, Chapter 265 (N.J.S. 2A:32C-1 to 2A:32c-17)

This law has three parts: (a) the main part authorizes the NJ Attorney General and whistleblowers to file false claims lawsuits similar to what is authorized under the Federal False Claims Act, and has similar whistleblower protections; (b) another part makes violations of the NJ False Claims Act also give rise to liability under the NJ Medical Assistance and Health Services Act; and (c) a third part amends the NJ Medical Assistance and Health Services Act to increase the $2000 per false claim civil penalty to the same level provided for under the Federal False Claims Act, currently between $5,500 and $11,000 per false claim.

New Jersey Medical Assistance and Health Services Act – Criminal Penalties, N.J.S. 30:4D-17(a)-(d)
Provides for criminal penalties for individuals and entities engaging in fraud or other criminal violations relating to Title XIX-funded programs. Fraudulent activities include 1) fraudulent receipt of payments or benefits; 2) false claims, statements or omissions, or conversion of benefits or payments; 3) kickbacks, rebates and bribes; and 4) false statements or representations about conditions or operations of an institution or facility to qualify for payments. Penalties include fines and/or imprisonment.

New Jersey Medical Assistance and Health Services Act – Civil Remedies, N.J.S. 30:4D-7.h., N.J.S. 30:4D-17(e)-(i); N.J.S. 30:4D-17.1.a.:
Violations of N.J.S. 30:4D-17(a)-(d) can result in civil sanctions: (a) unintentional violations: recovery of overpayments and interest; (b) intentional violation, or violation of the New Jersey False Claims Act discussed above: recovery of overpayments, interest, up to triple damages, and based on a recent amendment in the NJ False Claims Act, between $5,500 and $11,000 for each false claim. Recovery can be obtained against any individual or entity responsible for or receiving the benefit or possession of the incorrect payments. Violations can also result in the exclusion of an individual or entity from participation in all health care programs funded in whole or in part by the N.J. Division of Medical Assistance and Health Services.

New Jersey Health Care Claims Fraud Act N.J.S. 2C:21-4.2 & 4.3; N.J.S. 2C:51-5
Provides for criminal penalties for health care claims fraud, including the submission of false claims to programs funded in whole or in part with state funds by: 1) A practitioner who knowingly or recklessly commits health care claims fraud in the course of providing professional services is guilty of a crime of the second degree, and is subject to a fine of up to 5 times the monetary benefits obtained or sought to be obtained and to permanent forfeiture of his license; or 2) A person who is not a practitioner subject to paragraph a. above (for example, someone who is not licensed, registered or certified by an appropriate State agency as a health care professional) is guilty of a crime of the third degree if that person knowingly or recklessly commits health care claims fraud.

New Jersey Conscientious Employee Protection Act, "Whistleblower Act", N.J.S.A. 34:19-4
This "Whistleblower Act" is the NJ law that protects individuals within an organization who observe activities or behavior that may violate the law in some manner and who report their observations either to management or to governmental agencies. Employees can report compliance concerns in good faith without fear of retaliation or negative treatment. You can refer to Virtua's CEPA Notice on the VINE under "Corporate Corner".

VIRTUA POLICIES AND PROCEDURES

Virtua's Corporate Compliance Program establishes and maintains standards through the Code of Conduct and provides a method for employees to report actions or behavior that violate our policies or procedures or any violation of law. Virtua strongly encourages employees to address questions and concerns through the use of the chain of command which is: 1) your supervisor; 2) Another member of management at your facility, 3) Your Human Resources representative. Employees can also contact the Corporate Compliance Officer. Additionally, a Compliance Hotline (800) 268-0502 is available for employees. Corporate Compliance concerns are kept confidential to the greatest extent possible. Virtua will not take any disciplinary action or treat any employee negatively for using the chain of command or Compliance Office or Hotline to report in good faith any concern. The full policy is located in Virtua's Leadership Manual under the Fraud and Abuse Prevention Policy, and can be accessed on the Virtua Vine.