I. PURPOSE:

To provide guidance and information relative to the role of certain federal and state laws in preventing and detecting fraud, waste, and abuse in federal health care programs.

II. POLICY:

This policy applies to all employees, contractors, and agents of Aurora Health Care, Inc. and its affiliates (collectively “Aurora”).

It is Aurora’s policy to provide health care services in a manner that complies with applicable federal and state laws and that meets the high standards of business and professional ethics. No action, whether large or small, will be deemed to be for the benefit of Aurora Health Care if it is in violation of any law or regulation. To further this policy, and to comply with Section 6032 of the Deficit Reduction Act of 2005, Aurora provides the following information and guidance. See also the Code of Excellence, Aurora’s Compliance Plan, which can be accessed on the Compliance website on iConnect.

A. Aurora’s Detection and Prevention of Fraud, Waste, and Abuse

1. Aurora employs various auditing and other techniques, using appropriately credentialed staff and external consultants, to detect and prevent fraud, waste, and abuse.

2. Every Aurora employee has the duty to report any improper conduct, either intentional or unintentional, so that it may be corrected. A report may be made to:
   a. Your supervisor;
   b. Your business unit’s compliance officer;
   c. The Director of Corporate Compliance or the Chief Compliance Officer;
   or
   d. Via Aurora’s anonymous hotline: (888) 847-6331. Calls to the hotline will not be traced and anonymity of the caller will be preserved up to the limits of the law.

   Contact information for Aurora’s compliance officers can be found on the Compliance website on iConnect.

3. All concerns, either reported or identified via an audit, will be taken seriously and will receive prompt attention. Where appropriate, formal investigations will be conducted discreetly and professionally.
DETECTING AND RESPONDING TO FRAUD, WASTE, AND ABUSE #174


1. The federal False Claims Act imposes liability on any person or entity who knowingly does any of the following with regard to Medicare, Medicaid, or any other federally funded health care program.
   - Files a false or fraudulent claim for payments;
   - Uses a false record or statement to obtain payment on a false or fraudulent claim; or
   - Conspires to defraud to have a false or fraudulent claim paid.

   "Knowingly" means having knowledge, and acting in deliberate ignorance or reckless disregard, of the fact that the claim is false.

2. A person or entity found liable under the False Claims Act is, generally, subject to civil monetary penalties of between $5,000 and $10,000 per claim plus three times the amount paid for each claim that is filed that is determined to be false.

3. Anyone may bring a qui tam action under the False Claims Act in the name of the United States. The government may choose to participate in the case, and if so, the person who filed the action will receive between 15% and 25% of any recovery, depending upon the contribution of that person to the prosecution of the case. If the government does not participate in the case, the person who filed the action will be entitled to between 25% and 30% of any recovery, plus reasonable expenses and attorneys’ fees and costs.

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

1. 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 False Claims Act. The PFCRA imposes liability on people or entities that file a claim that they know or have reason to know:
   - Is false, fictitious, or fraudulent;
   - Includes or is supported by any written statement that contains false, fictitious, or fraudulent information;
   - Includes or is supported by a written statement that contains false, fictitious, or fraudulent, and the person or entity submitting the statement has a duty to include the omitted fact; or
   - Is for payment for property or services not provided as claimed.

2. A violation of this section of the PFCRA is punishable by a $5,000 civil penalty for each wrongfully denied claim, plus an assessment of twice the amount of any unlawful claim that has been paid. In addition, a person or entity violates PFCRA if they submit a written statement that they know or should know:
   - Asserts a material pact that is false, fictitious, or fraudulent; or
   - Omits a material fact that they had a duty to include, the omission caused the statement to be false, fictitious, or fraudulent, and the statement contained a certification of accuracy.

3. A violation of this section of the PFCRA carries a civil penalty of up to $5,000 in addition to any other remedy allowed under other laws.

D. State False Claims Law (Medicaid Fraud Statute, s. 49.49(1), Wis. Stats)
1. Wisconsin’s Medicaid fraud statute prohibits any person from:

- Knowingly and willfully making or causing to be made a false statement or misrepresentation of a material fact in a claim for Medicaid benefits or payments.
- Knowingly and willfully making or causing to be made a false statement or misrepresentation of a material fact for use in determining rights to Medicaid benefits or payments.
- Having knowledge of an act affecting the initial or continued right to Medicaid benefits or payments or the initial or continued right to Medicaid benefits or receiving the benefits or payments, concealing or failing to disclose such event with an intent to fraudulently secure Medicaid benefits or payments whether in a greater amount or quantity than is due or when no benefit is authorized.
- Making a claim for Medicaid benefits or payments for the use or benefit of another, and after receiving the benefit or payment, knowingly and willfully converting it or any part of it to a use other than for the use and benefit of the intended person.

2. Anyone found guilty of the above may be imprisoned for up to six years, and fined not more than $25,000, plus three times the amount of actual damages.

E. Wisconsin’s False Claims Statute (s. 20.931, Wis. Stats)

1. Wisconsin’s Medicaid (or “medical assistance”) false claims statute prohibits any person from:

- Knowingly presenting (or causing to be presented) a false claim for Medical Assistance;
- Knowingly making or using (or causing to be presented) a false record or statement to obtain approval for or payment of a false claim for Medical Assistance;
- Conspiring to defraud the State by obtaining allowance or payment of a false claim for medical assistance or by knowingly making or using (or causing to be made or used) a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Medical Assistance program;
- Knowingly making or using (or causing to be made or used) a false record or statement to conceal, avoid or decrease an obligation to pay or transmit money or property to the Medical Assistance program;
- Benefiting from the submission of a false claim for Medical Assistance, knowing that the claim is false, and failing to disclose the false claim to the State within a reasonable time after the person becomes aware that the claim is false.

2. A person or entity found liable under Wisconsin’s Medicaid false claim statute is, generally, subject to monetary penalties between $5,000 and $10,000 per claim plus up to three times the amount paid for each claim that is determined to be false.

3. Anyone may bring a *qui tam* action under WI s. 20.931 in the name of the State of Wisconsin. The state government may choose to participate in the case, and if so, the person who filed the action will receive between 15% and 25% of any recovery, depending upon the contribution of that person to the prosecution of the case. If the government does not participate in the case, the person who filed
the action will be entitled to between 25% and 30% of any recovery, plus reasonable expenses and attorneys’ fees and costs.

F. Anti-Retaliation Protections

1. Aurora prohibits any retribution against an employee for reporting a concern or raising a question, including callers who report via the compliance hotline. Aurora’s Code of Excellence provides information on how to report a compliance concern. In addition, each employee of Aurora annually signs a statement indicating the individual’s understanding of the Code of Excellence and obligation to internally report any compliance concerns.

2. Individuals within Aurora 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 are provided protections under certain laws. For example:

a. The federal False Claims Act as well as Wisconsin’s false claim statute include protections for people who file *qui tam* lawsuits as described above. The False Claims Act 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 actions 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.

b. Wisconsin’s Health Care Worker Protection (s. 146.997) also protects health care workers who disclose any of the following to an appropriate individual or agency:

   i. Information that a health care facility or provider has violated any state law or rule or federal law or regulation;

   ii. A situation in which the quality of care provided by, or by an employee of, the health care facility or provider violates established standards and poses a potential risk to public health or safety.

   Specifically, the health care facility or provider cannot take disciplinary action against an individual who reports the above in good faith. A health care facility or provider who violates this statute shall be subject to not more than $1,000 for a first violation.

G. Role of False Claims Law

1. The false claims laws above are an important part of preventing and detecting fraud, waste, and abuse in federal and state health care programs because they provide governmental agencies the authority to seek out, investigate and prosecute fraudulent activities. Enforcement activities take place in the criminal, civil, and administrative arenas. This provides a broad spectrum of remedies to these problems.
2. 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 in the False Claims Act, create reasonable incentives for this purpose. Employment protections create a level of security employees need in order to help in prosecuting these cases. Aurora also recognizes that open discussion of ethical and legal issues without fear of retribution is vital to the effectiveness of its compliance program.

Any individual with questions about this policy is invited to contact Aurora’s Chief Compliance Officer, Director or Corporate Compliance, or another line of service compliance officer. Contact information for these individuals is included in Aurora’s Code of Excellence, which can be accessed on the Compliance website on iConnect.