TITLE: PREVENTING AND REPORTING FRAUD, ABUSE AND WRONGDOING

PURPOSE: To provide Harris Health System's "commitment to compliance" and to reinforce processes for detecting, preventing, and reporting fraud, abuse, and wrongdoing.

POLICY STATEMENT:

Harris Health System (Harris Health) will comply with applicable laws and regulations, including, but not limited to, the Deficit Reduction Act of 2005, the Federal False Claims Act, the Fraud Enforcement and Recovery Act, the Patient Protection and Affordable Care Act, and the Texas Medicaid Fraud Prevention Act. Harris Health supports the efforts of federal and state authorities in identifying incidents of fraud, abuse, and wrongdoing and has implemented procedures to prevent and detect fraud, abuse, and wrongdoing.

This policy provides:

1. An overview of applicable federal and state laws used by the government to enforce compliance with federal and state health care program requirements; and
2. A discussion of the responsibilities and methods available to all members of Harris Health's Workforce in detecting, preventing, and reporting fraud, abuse or wrongdoing.

POLICY ELABORATION:

I. DEFINITIONS:

A. **ABUSE:** Incidents or practices that are not fraudulent but are inconsistent with generally accepted medical, business, or fiscal practices. Abuse may be unintentional.

B. **FEDERAL HEALTH CARE PROGRAM:** Any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States government. Some of the Federal Health Care Programs include, but are not limited to:

1. Medicare;
2. Medicaid;
3. Public Health Services;
4. Railroad Retirement Board program(s);
5. Black Lung Program;

6. TRICARE/Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)/Department of Defense health care programs;
7. Veterans Administration programs; and
8. Certain state healthcare programs.

C. **FRAUD:** Any act characterized by deceit, concealment, or violation of trust; an intentional, knowing, or reckless misstatement of fact that is believed, acted upon, and results in harm. Fraud can include, but is not limited to:

1. Violations of Federal or State False Claims Act laws;
2. Theft of time;
3. Diversion of revenue;
4. Charging Harris Health for expenses or capital items without authorization;
5. Misstatement of financial accounts;
6. Theft or misappropriation of Harris Health assets; or
7. Unreported conflicts of interest.

D. **WHISTLEBLOWER PROTECTION:** Those provisions of federal and state law that prohibit retaliatory action for reporting violations of law.

E. **WORKFORCE:** Harris Health Board of Managers, employees, medical staff, trainees, contractors, volunteers, and vendors.

F. **WRONGDOING:** Any action that fails to conform to Harris Health's Code of Conduct; applicable federal and state laws, rules and regulations; and Harris Health policies and procedures.

II. BACKGROUND:

A. Harris Health has a Corporate Compliance Program (Compliance Program) to promote adherence to applicable federal and state laws and the program requirements of federal, state, and private health plans.

B. The federal government and the State of Texas have enacted criminal, civil, and administrative laws that prohibit the submission of false or fraudulent claims and the making of false statements to federal and state governments. These laws contain various criminal, civil, and administrative penalties and provide governmental authorities with broad authority to investigate allegations of Fraud, Abuse, and

Wrongdoing and to enforce compliance with federal and state health care program requirements.

C. Section 6032 of the Deficit Reduction Act of 2005 (DRA) requires that any entity receiving or making annual Medicaid payments exceeding five million dollars ($5,000,000) establish and disseminate to all of its employees (including management) and contractors written policies that set forth the entity's policies and procedures for preventing and detecting Fraud, Abuse, and Wrongdoing in Federal Health Care Programs and that describe the federal and state false claims laws.

D. The Federal False Claims Act (FCA) imposes liability on any person who submits a claim to the federal government that he or she knows (or should know) is false.

1. The FCA provides that anyone who:

   a. Knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval;
   b. Knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim;
   c. Conspires to commit a violation of the FCA;
   d. Has possession, custody, or control of property or money used, or to be used, by the government and knowingly delivers, or causes to be delivered, less than all of that money or property; or
   e. Knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the government, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the government is liable to the federal government for a civil penalty of not less than five thousand dollars **($5,000)** and not more than ten thousand dollars **($10,000),** as adjusted by the Federal Civil Penalties Inflation Adjustment Act of 1990, ***plus*** **3 times the amount of damages,** which the government sustains.

2. "Knowingly" in the context of the FCA means:

   a. Actual knowledge of the information;
   b. Deliberate ignorance of whether the claim or statement is true or false; or
   c. Reckless disregard for whether the claim or statement is true or false.

Liability under the FCA requires no proof of specific intent to defraud.

3. The FCA also allows private parties to bring an action on behalf of the United States. These private parties, known as "*qui tam* relators," may share in a percentage of the proceeds from an FCA action or settlement.
4. The FCA provides protection to *qui tam* relators ("whistleblowers") who are discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of their employment as a result of their furtherance of an action under the FCA.

E. *The Texas Medicaid Fraud Prevention Act* (FPA) is substantially similar to the FCA. The actions that trigger civil and criminal penalties under the FPA are consistent with provisions of the FCA and include making a false statement or concealing information that affects the right to a Medicaid benefit or payment and conspiring to defraud the State by obtaining an unauthorized payment from the Medicaid program or its fiscal agent. In addition, under the FPA, a person may be liable if he presents a claim for payment under the Medicaid program for a product or service that was rendered by an unlicensed provider or that has not been approved by the patient's treating healthcare practitioner.

1. The damages and penalties for violating the FPA may include:

    a. Applicable monetary refunds to the State with interest;
    b. Civil penalties of (a) not less than five thousand dollars **($5,000)** or more than fifteen thousand dollars **($15,000)** per violation if the unlawful act results in injury to an elderly person, a disabled person, or a person younger than eighteen (18) years of age or (b) not less than five thousand dollars **($5,000)** or more than ten thousand dollars **($10,000)** for each violation that does not result in injury to a person as described above, (c) ***plus*** **two (2) times the amount of the payment** or the value of benefit received.

2. Like the FCA, the FPA has a provision that permits whistleblowers to bring an action on behalf of the State and receive a portion of the recovery if the case is successful. The private individual's share could be reduced or eliminated altogether, however, if the individual planned and initiated the activity upon which the lawsuit was based or if the individual is convicted of criminal conduct arising from his role in the illegal activity. Like the FCA, the FPA includes

provisions to prevent employers from retaliating against employees for their involvement in FPA actions.

F. The Fraud Enforcement and Recovery Act (FERA) was enacted in 2009 and expanded the FCA by:

1. Extending liability under the FCA to indirect recipients of federal funds and to the retention of overpayments even where there is no false claim;
2. Appropriating additional federal funding for anti-fraud enforcement;
3. Including whistleblower protections; and
4. Increasing the statute of limitations under the federal FCA so that the government can look back as far as fifteen (15) years.

G. The Patient Protection and Affordable Care Act (PPACA) was enacted in 2010 and is also related to the federal government's efforts against Fraud, Abuse, and Wrongdoing and:

1. Established that the failure to report and return an overpayment within sixty (60) days of identifying its existence can give rise to liability under the FCA;
2. Increased criminal penalties for health care Fraud offenses involving more than one million dollars ($1,000,000) in losses;
3. Enhanced oversight of providers and suppliers participating in or enrolling in Medicare, Medicaid and CHIP through mandatory licensure checks;
4. Added three hundred and fifty million dollars ($350,000,000) in funding over the next ten (10) years to help fight health care Fraud;
5. Provided for the sharing of data among federal agencies to help identify criminals and prevent Fraud;
6. Required providers and suppliers establish plans detailing how they will follow the rules and prevent Fraud as a condition of enrollment in Medicare, Medicaid or CHIP; and
7. Expanded Recovery Audit Contractors (RACs) to Medicaid, Medicare Advantage and Part D (the Medicare Drug Benefit Plan).

H. Examples of Fraud, Abuse, or Wrongdoing include, but are not limited to:

1. A provider who submits a claim to Medicare for payment of patient care items or services that he or she knows were not provided.

2. A hospital that disregards reports by hospital billing personnel that claims for services to Medicare or Medicaid are not supported by medical documentation and continues to submit the claims.
3. A provider who submits a claim to Medicare or Medicaid that is coded for services at a higher level than the services actually provided ("upcoding") or billing for portions of a procedure that have been identified as one single procedure ("unbundling").
4. Delivering health care services without a proper license.
5. Misrepresenting procedures or diagnoses in order to obtain payment for non-covered services.

III. RESPONSIBILITIES AND PREVENTION:

A. All Workforce members must conduct themselves in an ethical and legal manner as defined in the Harris Health Code of Conduct (Code).

B. Workforce members have an affirmative duty to report potential or suspected incidents of Fraud, Abuse, and other Wrongdoing.

C. The Senior Vice President of Corporate Compliance and Corporate Compliance Officer (CCO), in consultation with the Harris County Attorney's Office (County Attorney's Office), has responsibility for receiving and acting upon all information suggesting the existence of possible Fraud, Abuse, or Wrongdoing and for directing or transferring to appropriate departments all investigations arising from this information.

D. Harris Health has implemented several policies and procedures supporting its efforts to prevent and detect violations of federal and state health care program requirements and Harris Health's own policies and procedures, including the following:

1. *Code.*

   Harris Health has implemented the Code as a foundation document for its Compliance Program that applies to everyone doing business with Harris Health. The Code is made available on the Internet and Intranet. All Workforce members must abide by the Code.

2. *Open Door Policy and Affirmative Duty to Report.*

Harris Health has an open door policy that encourages employees, contractors, and agents to report problems, concerns, and perceived violations. All Workforce members are responsible for reporting potential or suspected incidents of Fraud, Abuse or other Wrongdoing. Employees, contractors and agents are encouraged to discuss questions or concerns with their direct supervisor, contact a member of the Harris Health management team, call the CCO directly, or call the Compliance Hotline. Harris Health employees may also contact the County Attorney's Office or Human Resources. The affirmative duty to report suspected violations of law, the Code, or compliance policies is addressed further in the Code.

3. *Harris Health Compliance Hotline.*

Harris Health has established a confidential telephone hotline for reporting Fraud, Abuse, or Wrongdoing. The Compliance Hotline is a toll-free telephone number and is available to all Workforce members twenty-four (24) hours a day by calling **1-800-500-0333**. Workforce members are encouraged to use the Compliance Hotline. Callers to the Compliance Hotline may remain anonymous or may request their information be kept confidential. In addition, a post office box is available for reporting concerns to the Office of Corporate Compliance (Compliance Office) P.O. Box 300033, Houston, Texas 77054.

4. *Non-Retaliation Policy.*

Harris Health will ensure its Workforce members who report problems and concerns in good faith are protected from retaliation and retribution. It is Harris Health's policy that no disciplinary action or retaliation be taken against anyone reporting a perceived issue, problem, concern, or violation to management, Human Resources, the Compliance Office, the County Attorney's Office, Harris Health's accrediting organization, a federal or State regulatory body or the Compliance Hotline "in good faith" or acting as a whistleblower pursuant to the FCA, the FPA, or other applicable law. Any form of retaliation against anyone reporting Fraud, Abuse, or Wrongdoing in good faith or cooperating with an investigation regarding a potential compliance issue is

strictly prohibited and will result in disciplinary action up to and including termination.

5. *Responding to Complaints and Allegations.*

Upon receipt of a report or notice of suspected noncompliance with any criminal, civil, or administrative law, the CCO will conduct an "Initial Inquiry" into the alleged noncompliance. If Fraud, Abuse or Wrongdoing is suspected, the CCO, in conjunction with the appropriate supervisor or manager, will consult with the County Attorney's Office prior to directly confronting an individual related to an alleged Fraud, Abuse or violation of other applicable law. If the Initial Inquiry indicates that there is sufficient evidence of possible Fraud, Abuse or noncompliance, an investigation will be conducted in accordance with Harris Health policies and procedures. Upon completion of an investigation, corrective action measures will be implemented to prevent similar problems from occurring in the future. Additional information on the conduct of investigations is included in Harris Health's Office of Corporate Compliance and Legal Counsel Protocols and Procedures Policy and Office of Corporate Compliance Coordination with Human Resources Policy.

6. *Enforcement and Discipline.*

Harris Health will take appropriate and consistent disciplinary and enforcement action (*i.e.*, corrective action plans, employment discipline up to and including termination, or contract termination) against Workforce members whose conduct is not in compliance with Harris Health's compliance policies, the Code, or any federal or state law or regulation.

7. *Training and Education.*

The development and implementation of regular, effective education and training programs for Workforce members is an integral part of the Compliance Program. Additional information about the Harris Health compliance and training program is included in the Compliance Education and Training Policy.

8. *Cooperation with Investigations.*

All Workforce members must cooperate with Compliance Office investigations and federal and state agencies that conduct investigations of Fraud, Abuse or Wrongdoing.

REFERENCES/BIBLIOGRAPHY:

Harris Health System Code of Conduct

Harris Health System Policy and Procedures 3.36, Compliance Hotline

Harris Health System Policy and Procedures 3.37 Corporate Compliance Department and Legal Counsel Protocols

Harris Health System Policy and Procedures 3.34 Corporate Compliance Department Coordination with Human Resources

Harris Health System Policy and Procedures 3.58 Non-Retaliation for Reporting Fraud, Abuse, or Wrongdoing

28 U.S.C. § 2461, *Mode of Recovery*

31 U.S.C., Chapter 37, as amended, *Claims*

31 U.S.C. Chapter 38, *Administrative Remedies for False Claim and Statements*

42 C.F.R. Part 1003, *Civil Money Penalties, Assessments and Exclusions*

45 C.F.R. Part 79, *Program Fraud Civil Remedies*

TEX. HUMAN RES. CODE, Chapter 36, *Medicaid Fraud Prevention*

1 T.A.C. Chapter 371, *Medicaid and Other Health and Human Services Fraud and Abuse Program Integrity*

Patient Protection and Affordable Care Act, Pub. L. No. 111-148 (2010)

Fraud Enforcement and Recovery Act of 2009, Pub. L. No. 111-21 (2009)

OFFICE OF PRIMARY RESPONSIBILITY:

Harris Health System Office of Corporate Compliance

REVIEW/REVISION HISTORY:

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		Approved 11/20/2007	Harris Health Policy Review Committee
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